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RURAL HEALTH CARE FOR THE ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

SIOUX FALLS, SD

MAY 29, 1990

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RURAL HEALTH CARE FOR THE ELDERLY

TUESDAY, MAY 28, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Sioux Falls, SD.

The committee met, pursuant to notice, at the Prince of Peace Home, Sioux Falls, SD, Senator Larry Pressler presiding.

Present: Senator Pressler and Representative Tim Johnson.

OPENING STATEMENT OF SENATOR LARRY PRESSLER

Senator PRESSLER. I would like to welcome you here. I think we're very privileged to be here at the Prince of Peace Home. I just took a tour of the various wings and it is a beautiful facility. There is a great feeling of warmness among the Presentation Sisters and the nurses, doctors, and administrators who manage and operate this facility. I was educated by the Presentation Sisters of Aberdeen, so if I say anything—if my grammer is bad this morning, it's the Presentation Sisters' fault.

I want to welcome everyone to this official hearing of the Senate Special Committee on Aging. I am pleased to see so many people interested in health care for the elderly. A special welcome to my colleague in Congress, Representative Tim Johnson, from whom we will be hearing. I want to thank the expert witnesses who are here for taking time from their busy schedules to come this morning and share their ideas on the subject of health care for the elderly. A special thanks to Wayne Muth and Gary Tuschen.

WELCOMING REMARKS BY GARY TUSCHEN

Mr. TUSCHEN. I, too, want to welcome everyone. Thank you for coming. Certainly it is a lovely day. We're encouraged by our weather, our recent rains. We have a lot to look forward to. We're also encouraged by the Congressman's presence here today because certainly vision for the nineties is long-term health care and what we need to do to provide that care. So hopefully, today, we'll get an understanding of our expert panelists' ideas, and I encourage all of you to share your ideas and your questions. So again welcome you. Thank you for coming. Thank you, Senator.

Senator PRESSLER. Thank you. The purpose of today's hearing is to examine three issues. First, the cost of nursing home care. Second, the skyrocketing cost of supplemental—Medigap—premiums. Third, the limits on the type of services paid by Medicare.

Making long-term care, including nursing home care, more affordable is a subject of two congressionally mandated commissions.

One is the U.S. Bipartisan Commission on Comprehensive Health Care, also named the Pepper Commission, and the Advisory Council on Social Security, the Steelman Commission, which is under the Secretary of Health and Human Services. The Pepper Commission disseminated its recommendations in March 1990.

I'm going to ask each of the witnesses if they could summarize to about 5 minutes so we have time for questions. We have to be through here at about 10 minutes to 12, and then we'll have time for questions.

We have two commissions who are now looking at the cost of long-term care. This is an issue that faces 5.5 million elderly living in the community, and they will need some long-term care. The number is projected to grow to 6.7 million by the year 2000, and 9.4 million by 2020. So as our population lives longer, we have more and more of a problem with long-term care. One in two persons age 65 and older will spend some time in a nursing home, and one in four will spend a year or more, so I always say to audiences even if you don't have a relative in a nursing home, there's a one-in-two chance that if you survive to 65 that you're going to live in a nursing home some day so everybody should be interested. We all have an interest in what's going on in our retirement homes and our nursing homes even though we may feel young and vigorous. Between 1989 and the year 2000, the elderly nursing home population is projected to increase from 1.6 to 2.2 million and more than double again by the year 2040. The cost of providing nursing home care in 1987 was $41.6 billion. That averages out to approximately $30,000 per person.

Who pays for the cost of nursing home care? Families of patients pay for 51 percent of the care, another 31 percent is paid by Medicaid, and Medicare picks up only 2 percent. Another 6 percent comes from a variety of other private insurance.

The long-term care provided in the home by a professional caregiver, such as a nurse, averages—costs an average of $45 to $60 per visit, and from $50 to $200 per day.

Solutions are needed to address the growing need for long-term care protection. A study of Families U.S.A. Foundation showed that the overwhelming majority of older Americans cannot afford the cost of a basic nursing home insurance policy. Most private policies provide limited coverage. For example, many do not cover the full cost of nursing home care and nearly all policies pay benefits for a limited period of time, usually 2 to 4 years.

I am here to learn what solutions you and the witnesses may have to meet the need for long-term care; what services should be included in a long-term care program; how can the cost of the program be financed; how can we finance quality nursing home care?

The skyrocketing costs of supplemental Medigap premiums are another concern for elderly individuals. Senior citizens with supplemental insurance policies experienced severe premium increases this year. Premium increases are a serious matter for all senior citizens but especially those on fixed income. Many Americans simply cannot afford the 7 to 20 percent premium increase they have experienced this year. Insurance companies lay the blame for premium increases on the 1989 repeal of the Medicare Catastrophic Coverage Act. In fact, long before that appeal occurred, insurance

companies were warning senior citizens that their premiums would skyrocket if the Catastrophic Program was repealed. However, the fact is that no more than one-half of the premium increases was due to the repeal of the Catastrophic Program. The other increases were due to health care inflation, increased utilization, and aging of the population. As a member of the Senate Aging Committee, I have participated in hearings on this problem. Supplemental insurance premium increases are excessive. Further, there are serious problems related to marketing abuses, such as high-pressure sales techniques and agent efforts to sell unnecessary policies. One solution which I am cosponsoring is a Health Insurance Counseling Bill. That legislation would provide grants to States to establish programs which would emphasize the use of trained volunteers to provide objective health insurance counseling to older Americans.

During the hearings on supplemental insurance Medigap premiums, the subject of expanding Medicare to cover more services was discussed. The subject was addressed within the context of eliminating supplemental insurance. That certainly is worth examination. I am looking forward to hearing from several witnesses today about that possibility.

A third option worthy of consideration is expanding Medicare coverage. Senior citizens are very concerned about extensive items they need, which are not covered by insurance or Medicare. These items often include dental work, eye care, and eyeglasses, chiropractic treatment and procedures, hearing aids, and nursing home care. The lack of coverage for many health care items and the upward spiral of supplemental Medigap insurance certainly is reason to examine the feasibility of expanding Medicare coverage. The examination must include an ongoing dialogue with older Americans. Failure to communicate with older Americans will only result in a program that is unacceptable to them. Financing additional coverage is an important part of that discussion, so that is why I am anxious to hear the views of our witnesses.

In conclusion of my opening statement, I want to say that insuring the availability of health care services for the rural elderly is my priority. I have heard from many South Dakotans regarding their concern about nursing home costs and the affordability of nursing home insurance, a lack of Medicare coverage for basic health benefits, and so forth. So we have a panel of expert witnesses here today, and first I'd be happy to call upon my colleague, Representative Tim Johnson. We welcome him to sit with the Committee this morning as a member. Tim, thank you very much for being here.

[The prepared statement of Senator Pressler follows:]

SENATE SPECIAL COMMITTEE ON AGING
HEARING
MAY 29, 1990
U.S. SENATOR LARRY PRESSLER, CHAIRMAN

I want to welcome everyone to this official hearing of the Senate Special Committee Aging. I am pleased to see so many people interested in the subject "Rural Health Care for the Elderly." A special welcome to my colleague in Congress -- Representative Tim Johnson. I am pleased that he could join us to share his views on the subject. Last, but not least, I want to thank the expert witnesses for taking time from their busy schedules to come this morning and share their ideas on the subject of rural health care for the elderly.

A special thank you to Wayne Muth (MOO-TH) and Gary Tuschen (TOO-SHEN) for arranging the hearing here at the Prince of Peace Retirement Center. It is appropriate that the hearing be held in an area where so many older Americans can attend.

The purpose of today's hearing is to examine three issues that the elderly regularly confront:

1. the cost of nursing home care
2. the skyrocketing cost of supplemental (Medigap) premiums
3 the limits on the type of services paid for by Medicare.

THE COST OF NURSING HOME CARE

Making long-term care, including nursing home care, more affordable is the subject of study by two congressionally-mandated commissions. One is the U.S. Bipartisan Commission on Comprehensive Health Care, also named the Pepper Commission, and the Advisory Council on Social Security (Steelman Commission) which is under the Secretary of Health and Human Services. The Pepper Commission disseminated its recommendations in March 1990. The Steelman Commission is expected to submit its report to the Secretary of Health and Human Services by January 1991.

The need for a long-term care program is recognized. Long-term care is a family issue: it is a grandfather with Alzheimer's Disease; a husband or wife who has suffered a stroke; a worker disabled by an accident; a grandmother immobilized by a broken hip; or a child with Cerebral Palsy.

In 1989, an estimated 5.5 million elderly living in the community will need some form of long-term care. That number is projected to grow to 6.7 million by the year 2000 and 9.4 million by 2020. The immediate questions are what specific programs should be included in a long-term care program and how to pay for the program.

One in two persons aged 65 and older will spend some time in a nursing home, and one in four will spend a year or more. Between 1989 and the year 2000, the elderly nursing home population is projected to increase from 1.6 to 2.2 million and more than double again to 4.6 million by 2040.

The cost of providing nursing home care in 1987 was $41.6 billion. That averages out to approximately $30,000 per person. Who pays for the cost of nursing home care? Families and patients pay for 51 percent of the care, another 41 percent is paid for by Medicaid and Medicare picks up only 2 percent. Another six percent comes from a variety of other private insurance.

The long-term care provided at home by a professional caregiver such as a nurse costs an average of $45 to $60 per visit and from $50 to $200 per day.

Solutions are needed to address the growing need for long-term care. Private insurance is inadequate to meet the need for long-term care protection. A study by Families USA Foundation showed that the overwhelming majority of older Americans cannot afford the cost of a basic nursing home insurance policy. Most private policies provide limited coverage: for example, many do not cover the full costs of nursing home care and nearly all policies pay benefits for a limited period of time usually two to four years.

I am here to learn what solutions you and the witnesses may have to meet the need for long-term care. What services should be included in a long-term care program? How can the cost of the program be financed? How can we finance quality nursing home care?

SKYROCKETING COST OF SUPPLEMENTAL (MEDIGAP) PREMIUMS

Senior citizens with supplemental insurance policies experienced severe premium increases this year. Premium increases are a serious matter for all senior citizens, but

especially for those on fixed incomes. Many older Americans simply cannot afford the seven to twenty percent premium increase that they have experienced this year.

Insurance companies lay the blame for premium increases on the 1989 repeal of the Medicare Catastrophic Coverage Act. In fact, long before that repeal occurred, which I opposed, insurance companies were warning senior citizens that their premiums would skyrocket if the catastrophic program were repealed. However, the fact is that no more than one-half of the premium increase was due to the repeal of the catastrophic program. The other increases were due to health care inflation, increased utilization and the aging of the population.

As a member of the Senate Aging Committee, I have participated in hearings on this problem. Supplemental insurance premium increases are excessive. Further, there are serious problems related to marketing abuses such as high pressure sales techniques and agent efforts to sell unnecessary policies. One solution which I am cosponsoring is the Health Insurance Counseling Bill. That legislation would provide grants to states to assist in establishing programs, which emphasize the use of trained volunteers, to provide objective health insurance counseling to older Americans.

During the hearings on Supplemental Insurance (Medigap) premiums, the subject of expanding Medicare to cover more services was discussed. The subject was addressed within the context of eliminating supplemental insurance. That certainly is worth examination. I am looking forward to hearing from several witnesses today about that possibility.

EXPANDING MEDICARE COVERAGE

Senior citizens are very concerned about expensive items they need but are not covered by insurance or Medicare. Those items often include dental work, eye care and eye glasses, chiropractic treatments and procedures, hearing aids and nursing home care. The lack of coverage for many health care items and the upward spiral of Supplemental (Medigap) Insurance certainly is reason to examine the feasibility of expanding Medicare coverage.

That examination must include an ongoing dialogue with the older Americans. Failure to communicate with the old Americans will only result in a program that is unacceptable to them. Financing additional coverage is an important part of that discussion. I am anxious to hear your views about that subject.

CONCLUSION

Ensuring the availability of health care services for the rural elderly is my priority. I have heard from many South Dakotans regarding their concerns about nursing home costs and the unaffordability of nursing home insurance, the lack of Medicare coverage for basic health benefits such as dental, eye and chiropractic care, and the severe supplemental insurance premium increases.

We have with us today a panel of witnesses who will provide me with their views on the issue of health care for the rural elderly. When the witnesses have completed their testimony there will be time for anyone to ask questions. The ideas and suggestions we receive today will be sent to other members of the Senate Aging Committee. This will help me and my colleagues as we develop legislation and consider proposed legislation.

STATEMENT OF CONGRESSMAN TIM JOHNSON

Representative JOHNSON. Well, thank you, Senator. I appreciate the invitation and the opportunity to join you here today for this important hearing, and I want to commend you for holding this hearing. I want to commend you for putting together an excellent staff of experts here on the panel. I'm looking forward to hearing from them, and then again, I think the greatest experts of all are the people who are here in the audience with us here today who are impacted in their lives on a day-by-day basis by the policy—policies that are effected in Washington, so thanks for this opportunity to testify at this hearing of the U.S. Senate Special Committee on Aging.

I am pleased to see the Committee focusing on absolutely critical issues of nursing home and long-term care costs, the high costs of supplemental or Medigap insurance, and the expansion of Medicare benefits. I've heard from a great many seniors all around the State of South Dakota about the severity of these problems, and I can't stress too much the need for Congress to make real progress in addressing these critical issues. The costs of nursing home and long-term care facing senior citizens have become a critical problem, one that affects thousands of South Dakotans, and the fact is, there is no income protection for people in this situation until they reach the point where virtually everything they've worked for is gone. Alternatives must be explored to address this critical situation for senior families.

In the last Congress, I was cosponsor of H.R. 3900 which would extend Medicare coverage to both home care and nursing home costs without raising Medicare premiums. Currently, millions of chronically ill seniors are forced to spend down their income and deplete their life savings in order to qualify for Medicaid to pay for nursing home costs. This is wrong, and it's time we offer these folks a way out, high quality, cost-effective health care coverage. It isn't right that these living expenses should cost someone their independence. We need to continue to fight for full funding of programs to help alleviate these burdens that these costs play in the elderly of our Nation.

Although the Medicare Catastrophic Coverage Act was repealed because of numerous problems with its funding methods, we were able to retain some extended benefits that will be at no cost to senior citizens, including some spousal impoverishment protection to help protect the assets of a spouse whose husband or wife must reside in a nursing home and a Medicaid buy-in provision for low-income elderly, but this is only a beginning and must be made a part of a much more comprehensive approach.

Long-term health care is an important issue. With an aging population growing at an increased rate, one that will need to be addressed by Congress, it makes no sense to me that our Nation spends billions of dollars in every corner of the planet and then claims poverty when it comes time to meet its commitments to Americans in such vital programs as long-term care and nursing home care and other vital care needs.

In the area of Medigap insurance, I think Congress must be looking at the serious problems facing seniors because of the large cost

increases and fraud in Medigap insurance policies. The General Accounting Office has reported average Medigap hikes this year of 20 percent, and some as high as 80 percent, and that $1 billion may be spent on unnecessary Medigap policies. We keep $1 billion in prospective, $1 billion is equivalent to the entire Federal and State budget of the State of South Dakota for a year. Legislation has recently been introduced in Congress to help prevent this type of Medigap fraud and abuse. I'm pleased to be a cosponsor of the House counterpart to the Senate bill, Senator, on Medigap fraud and abuse prevention, which I believe Congress needs to move on quickly. The major provisions of this legislation in the House is H.R. 4840, include establishing new consumer protection standards so the consumers can truly compare policies and make informed choices about coverage. Benefits and terminology would be simplified to make comparisons easier. Funds would be made available for States to provide counseling programs for Medigap purchasers and would establish a process to bar Medigap rate hikes if a company does not meet loss-ratio requirements. The States would supervise the rate hikes, and if a company fails to meet the loss-ratio, it would be required to make refunds, and the legislation would crack down on mail order policies and loopholes would be closed to help prevent duplication.

Presently, the programs of Medicare and Medicaid help to provide health insurance for the elderly, disabled, and underprivileged, but that coverage does not extend far enough and Congress must address this problem as our popluation continues to live longer and more seniors are in need of these necessary benefits. Congress needs to continue to oppose the huge cuts that have recently been proposed in Medicare and Medicaid and to work to support these programs that have become the only source of health care for so many while looking at all the options to expand that coverage in a cost-efficient manner.

There's currently a bill in the House of Representatives titled, "The Medicare Benefit Improvements Acts of 1990, H.R. 3880, which will begin to improve Medicare coverage for providing benefits that will help our Nation's elderly. I am pleased to say that I'm cosponsor of this bill, and I'll work hard for its passage. It's important that the elderly of South Dakota and the rest of our country are provided with the quality health care and the benefits contained in 3880, including mammography screening, home health services, hospice care and respite care would be of great assistance.

Again, I want to thank Senator Pressler and the Senate Special Committee on Aging for holding this hearing. I look forward to working with my colleagues in the Congress, Senator Pressler, and Senator Daschle, and the people of South Dakota in addressing and resolving these critical health care challenges. I'm looking forward to hearing the testimony of the experts on the panel here today, as well as the comments and the questions and concerns of people in the audience have. I have other obligations in another part of South Dakota that may cause me to have to leave the hearing before it's completely concluded, but I will be reviewing very closely the written report of testimony and sharing that with my staff in Washington. I also want to invite any and all of you if you ever have any questions or concerns about the complexities of health

care coverage, the programs that exist, the programs that ought to exist, then feel free, all of you, to contact my office, Senator Pressler's office—we work very closely together with our toll-free line and the mail and so on. We are a small State and there are disadvantages sometimes to that fact, but there are advantages in a sense that we know each other well. We have a good personal relationship, and we're back home in South Dakota often, and we want to make sure that we use our role as representing South Dakota in the most effective, positive, constructive fashion possible. It's only by your continued input and assistance with us that we can make sure that that, in fact, does take place.

Thank you again for this opportunity to share a few thoughts with you this morning, and most of all this opportunity to listen to your observations on where we ought to be going in American health care. Thank you.

[The prepared statement of Representative Tim Johnson follows:]

Testimony By Congressman Tim Johnson
before a hearing of the
U.S. Senate Special Committee on Aging
May 29, 1990
Prince of Peace Retirement Center, Sioux Falls, S.D.

Thank you for the opportunity to testify at this important hearing of the US Senate Special Committee on Aging. I am pleased to see the Committee focusing on important issues such as the high costs of nursing home and long term care, the high costs of supplemental or Medigap insurance and expanding of Medicare benefits. I have heard from many seniors in South Dakota about the severity of these problems, and so I am hopeful that Congress will be able to make real progress in addressing these critical issues.

HIGH COST OF NURSING AND LONG TERM CARE

The costs of nursing homes and long term care facing senior citizens have become a serious problem, one that affects many South Dakotans; and the fact is, there is no income protection for people in this situation until they reach the point where everything they've worked for is almost gone.

Alternatives must be explored to address this critical situation for senior citizens and their families. In the last Congress, I was a co-sponsor of H.R. 3900, which would extend Medicare coverage to both home care and nursing home costs without raising premiums. Currently, millions of chronically ill seniors are forced to "spend down" their income and deplete their life-savings in order to qualify for Medicaid to pay for nursing home costs. This is wrong, and it's time we offered these folks a way out -- high quality, cost-effective health care coverage that everyone's entitled to. It isn't right that these living expenses should cost someone their independence. I will continue to fight for full funding of programs to help alleviate the burdens these costs place on the elderly of our nation.

Although the Medicare Catastrophic Coverage Act was repealed because of lack of political support from senior citizens, we were able to retain some expanded benefits that will be at no cost to senior citizens, including some "spousal impoverishment" protection to help protect the assets of a spouse whose husband or wife must reside in nursing home, and a Medicaid "buy-in" provision for low income elderly.

Long-term health care is an important issue, and with an aging population growing at an increased rate, one that will need to be addressed by Congress. It makes no sense to me that the nation spends billions of dollars in every corner of the planet, and then claims poverty when it comes time to meet its commitments to Americans in such vital programs as long term care, nursing home care, and other vital needs.

SUPPLEMENTAL (MEDIGAP) INSURANCE

Congress must also look at the serious problems facing seniors because of the large increases and fraud in Medigap insurance policies. The General Accounting Office (GAO) has reported average Medigap hikes this year of 20 percent, and some as high as 80 percent, and that $1 billion may be spent on unnecessary Medigap policies. Legislation has been recently introduced in Congress to help prevent this type of Medigap fraud and abuse, and I am proud to be a cosponsor of the Medigap Fraud and Abuse Prevention Act.

The major provisions of HR 4840 include:

* establishing new consumer protection standards so that consumers can truly compare policies and make informed choices about coverage -- benefits and terminology would be simplified to make comparisons easier.

* funds being made available for states to provide counseling programs for Medigap purchasers.

* establishes a process to bar Medigap rate hikes if a company doesn't meet the loss ratio requirements -- the states would approve the rate hikes and if a company fails to meet the loss ratio, it will be required to make refunds.

* policies would have to be guaranteed renewable, the legislation would crack down on mail order policies, and loopholes would be closed to help prevent duplication.

EXPANDING MEDICARE BENEFITS

Presently the programs of Medicare and Medicaid help to provide health insurance for the elderly, disabled, and underprivileged. But that coverage does not extend far enough, and Congress must address this problem as our population continues to live longer and more seniors are in need of these necessary benefits.

I will continue to oppose the large cuts in Medicare and Medicaid proposed by President Bush and work to support these programs that have become the only source of health care for so many, while looking at all the options to expend that coverage in a cost efficient manner.

There is currently a bill in the House, titled the Medicare Benefit Improvements Act of 1990, H.R. 3880, which will begin to improve Medicare coverage by providing benefits that will help our nations elderly.

I am pleased to say that I am a co-sponsor of this bill, and I will work hard for its passage. It is important that the elderly of South Dakota and the rest of our country are provided with quality health care, and the benefits contained in H.R. 3880, including mammography screening, home health services, hospice care, and respite care go a long way toward providing that care.

CONCLUSION

Again, I would like to thank the Senate Special Committee on Aging for holding this important hearing, and I look forward to working with my colleagues in Congress and the people of South Dakota in solving these problems.

Senator PRESSLER. Tim, we thank you very much and we would look forward to hearing from you again this morning during the questions and answers.

Next, I'm going to call on Jim Ellenbecker. Jim is Secretary of the Department of Social Services, Pierre, SD. As you know, the State and Federal governments work very closely together. Jim is knowledgeable about the Medicaid reimbursement for long-term care. He will discuss the cost of nursing home care and the expansion of Medicare to cover all long-term care services.

I might just say again a point that I always make to audiences across South Dakota, even if they're high school audiences, is that if you survive to the age of 65, you've got a 50/50 chance of spending some time in a nursing home, so the odds are pretty high that we all might spend a little time there sometime, and I think it's good that we all learn a little bit more about some of the problems.

Jim, we'll hear from you at this point, and welcome here. Thank you very much for being here.

STATEMENT OF JIM ELLENBECKER, SECRETARY OF THE DEPARTMENT OF SOCIAL SERVICES, PIERRE, SD

Mr. ELLENBECKER. Thank you Senator Pressler, Congressman Johnson, fellow panelists. Maybe if I get a little bit closer. There we go. Thank you. I'd just like to talk to you about a couple of the issues today that the Committee—Select Committee is looking at.

First, I'd like to talk about the cost of nursing home care. No one is as concerned about the cost of nursing home care as the Department and the State of South Dakota. The Department's Medicaid program pays for 55 percent of the care for residents in South Dakota nursing homes each month. In fact, this represents about 38 percent of our State Medicaid budget. The cost is increasing dramatically. The State in fiscal year 1991, which is the period that starts July 1—the upcoming July 1, our Medicaid expenditures in the State will be $161 million, 66 percent of our Department's total budget, about $250 million. Sixty million dollars of that $160 million of the Medicaid budget is for about 4,582 individuals that will be residents in nursing homes this next year. Inflation is the largest single contributor to the increasing cost of Medicaid. In fiscal year 1991, which is starting July 1, our State Medicaid budget for nursing homes alone is about $10.2 million in increases to cover the increasing cost of inflation. That's up from $50 million in the year that we're presently in, up to $60 million for fiscal year 1991. This is all necessary because of what's happening with our aging population in this country. As Senator Pressler has mentioned, the elderly are the fastest growing segment of our population. This growth doubles that of any other population in our population base. Those individuals who are over 85 and the primary candidates for nursing home care in our State are growing twice as fast as our elderly population.

The cost of providing institutional care is extremely expensive, as I've said. The average cost of staying in a nursing home in South Dakota is $45 a day. That's about $17 thousand per person per year. The effect of the nursing home budget on our State Medicaid budget is important, too. By design, Medicaid is a reimburse-

ment process which has fostered an institutional bias, and that goes back to 1965 when Medicaid and Medicare were first developed. And we really weren't talking about a community-based alternative at that point in time. In 1988, however, Governor Mickelson launched a six-point plan designed, in part, to address the increasing financial burden of long-term care on the State. The thrust of the plan is to develop alternative long-term care services to complement the fully developed institutional care system that we have in our nursing homes.

With the cooperation of the 1988 legislature, a mandatory statewide preadmission assessment program to nursing homes was enacted, along with a moratorium on new nursing home beds. The purpose of the Preadmission Assessment Program is to provide the elderly and their families with needed information about alternatives at the time they are making important decisions about care for an elderly family member. The individual or their family makes the final decision. The department's recommendations are nonbinding. This process has already made a significant change in our health care delivery system for the elderly in the State. We have had over 600 individuals who have been provided alternatives to nursing home care after making an application to a nursing home in the State, and this is over the last 22 months. Our State initiative has prevented the projected development of an additional 1,000 to 1,500 nursing home beds by 1995. These beds would have cost an additional $10 million annually to the State Medicaid budget, had they been built.

Despite our efforts, the cost of nursing home care will continue to increase, and I think the primary reason for that are new Federal requirements—Federal requirements for nursing homes to spend money to do intensive nurse aide training and certification and then the cost—the additional cost of the nursing staff to provide quality of care in our nursing homes. I think the rising costs of salaries for those workers is going to be, in the years ahead, the primary reason for increasing nursing home costs.

Including nursing home care under the Medicare program will be extremely important. The impact of nursing home care on the State's budget is extreme. For all practical purposes, Medicare does not cover nursing home care. Many people mistakenly believe that Medicare benefits will help them pay for nursing home care, but the fact is today in South Dakota, we only have 16 of our 116 nursing home facilities that are even certified to participate in Medicare. As I said earlier, since 1965, Medicare policy has, in effect, not been responsible for providing long-term care to people within the State, and has really made that a State responsibility.

Our recommendations deal with changing Medicare policy. We would like to see a mechanism established to allow the State Medicaid program to recover the cost of nursing home care provided to those individuals who would have otherwise been Medicare eligible. The Department concurs with the Pepper Commission recommendation to establish nursing home programs which entitle all users of social insurance for the first 3 months of their stay in a nursing home to be paid for by Medicare. We think the Pepper Commission is very direct in this particular approach, and the State fully supports that approach. Federal policies should also be developed to

foster incentives for development of alternative community-based, long-term care services as integral components of a national long-term care system.

In conclusion, caring for the elderly will become one of the most important health and social service tasks in the next 20 years. Government providers and consumers of long-term care are all recognizing that the present system is not structured to meet the needs of our expanding elderly population. Careful planning is necessary to provide an adequate and appropriate long-term care system for the future. Thank you.

[The prepared statement of Mr. Ellenbecker follows:]

Testimony For

SENATE AGING COMMITTEE HEARING

Rural Health Care for the Elderly
U.S. Senator Larry Pressler

By

James W. Ellenbecker, Secretary
of the
South Dakota Department of Social Services

I. The Cost of Nursing Home Care in South Dakota

No one is as concerned about the cost of nursing home care in South Dakota as the State of South Dakota and the Department of Social Services. The Department of Social Services' Medicaid program pays for the care of over half (53 to 55 percent) of all nursing home care residents. In fact, the state spends nearly 38 percent of its Medicaid budget for nursing home care.

The cost of providing long term care is increasing dramatically. In Fiscal Year 1991, Medicaid expenditures will comprise $161.3 million, approximately 66 percent of the department's $248 million annual budget. Over $60 million of the state's Medicaid budget is allocated for the care of 4582 nursing home residents. What's more, inflation is the largest single contributor to the increasing cost of Medicaid in South Dakota. In FY 1991 the department increased its Medicaid budget $10.2 million over the previous year for nursing home care alone.

An Aging Population. Growth in the cost of nursing home care is related to the rising number of elderly South Dakotans, as a growing elderly population fuels demand for an increasing array of long term care services.

In fact, the elderly are the fastest growing population group in the country, generally growing twice as fast as the rest of the population. There are more than 100,000 persons over age 65 in South Dakota, comprising 14 percent of the state's population. At the same time the number of elderly over age 85 is increasing more than twice as fast as all elderly.

The elderly are considerably more expensive to maintain, especially where quality of life is at issue. Most elderly live in their own homes and need more services than younger people. Medical costs alone for the over-65 population average almost twice that of people under 65. While people over 65 are only 12 percent of the national population they fill a third of the nation's hospital beds. They also account for two out of every five office calls to a doctor. Studies show that 80 percent of the elderly suffer from "chronic" diseases such as high blood pressure and other conditions involving major organ systems.

South Dakota has about 7,700 elderly persons in nursing homes. This is 7.3 percent of the state's elderly population compared to 5 percent nationally. In addition, recent data indicates that South Dakota has 30 more nursing home beds per thousand elderly than the national average.

The cost of providing institutional care to the 4582 Medicaid recipients in South Dakota nursing homes is extremely expensive. The average cost of staying in a nursing home in South Dakota, across all levels of care, is over $45 per day or $17,000 per year per person.

II. The Effect of Nursing Home Care on the State Medicaid Budget

However appropriate, institutional long term care has grown unchecked for 30 years. Medicaid reimbursement has fostered overdevelopment of the State's long term care system in terms of institutional care at the expense of community-based alternatives.

In South Dakota alone nearly one-third (34) of the state's 116 nursing homes are private, for-profit operations. What's more, about a half of these facilities are owned by one corporate nursing home enterprise that is so large it alone is able to impact the state's Medicaid rate-setting structure. Nursing homes chains run by religious organizations have also grown into large nursing home operations.

As many investors already know, the health care industry provides a lucrative return on investment. Readily available cash has greatly stimulated the growth of private enterprise involvement in both long term care and health care. With increasing numbers of elderly needing health and long term care, geriatrics became the growth industry of the eighties.

Unfortunately, increasing commercialization of health and long term care has serious consequences for the poor and those agencies that must bear the cost of caring for them. As nursing homes have evolved from "retirement centers" to medical facilities concerned with maximizing profits, many facilities became licensed to provide levels of care they weren't providing to the majority of their patients. Skilled nursing facilities were able to receive a higher rate of reimbursement for all their patients regardless of the level of care provided. At the same time, many facilities minimized admissions of high-cost, intensive care patients. Ultimately, this meant increased costs for the state's Medicaid program. Implementation of a new reimbursement system mandated by the Omnibus Budget Reconciliation Act of 1987 should help address this problem somewhat.

Alternatives. As a result, the state has made a commitment to develop and finance alternative methods of caring for the increasing numbers of elderly. Some of these, such as homemaker services, home health care, congregate meals programs and others have already been proven successful, especially in that they allow elderly people to continue living with dignity in their own homes and communities at least until skilled nursing home care is really necessary. Although "preventative" services and other alternative living arrangements such as these are costly to develop and operate, they are a vital step in the direction necessary to curb runaway health care costs. Providing the programs and services necessary to keep the increasing numbers of elderly healthy and in their own homes is essential if the state is to maintain control over its health care costs.

In 1988, Governor George Mickelson launched a six-point plan designed in part to address the increasing financial burden of long term care on the state's Medicaid budget and change the state's long term care system from an emphasis on institutional care to developing alternative long term care services.

With the cooperation of the 1988 Legislature, a mandatory statewide preadmission assessment program was implemented July 1, 1988 for all persons seeking admission to nursing homes, along with a moratorium on expansion in the number of nursing home beds and expansion in community-based alternatives.

The purpose of this program was to insure that the elderly and their families are made aware of all the long term care options available to them--including nursing home placement. The individual or his family makes the final decision (assessment recommendations are non-binding) as to whether to accept the recommended alternatives or enter nursing home care despite assessment results.

This initiative is already bringing about a significant change in South Dakota's health care system for the elderly. In the 22 months since this initiative was implemented there has been significant progress in altering the public's view of their long term care needs. The program has been successful in providing long term care alternatives for elderly persons who would otherwise enter nursing home care.

The recognition that a patient's emotional needs are no less important than their physical needs has contributed greatly in persuading our elderly and disabled clients that there are resources in or near their community that can allow them to comfortably remain in their own homes longer. Over 600 individuals seeking admission to nursing homes have been diverted to alternatives since July 1, 1988.

State Initiatives. Offering alternative long term care services to those elderly who would otherwise occupy new nursing home beds forestalls increases in the number of elderly South Dakotans who ultimately become Title XIX eligible due to premature nursing home placement. Had the state failed in its responsibility to address the growth in nursing home admissions the state would have an additional 1,000-1,500 nursing home beds by 1995--at a cost of an additional $10 million annually to the state Medicaid budget.

Despite these initiatives, the cost of nursing home care will continue to increase due to federally-mandated requirements for nursing homes to spend more for nurse-aide training and certification and other activities designed to enhance quality of care for recipients. Passage of the Omnibus Budget Reconciliation Act of 1987 also requires states to change the way in which they reimburse nursing facilities for care provided to Medicaid residents by eliminating the distinction between skilled and intermediate care facilities and providing reimbursement more appropriate to the level of care actually provided to individuals within a facility.

III. Including Nursing Home Care in the Medicare Budget

The steadily rising number of elderly poses a serious economic question: How will the nation bear the cost of caring for so many older people?

The graying of America is already bringing changes to our society. In the last ten years politicians have begun to feel the considerable political pressure wielded by their elderly constituents demanding new social programs. That the economy is already feeling the burden of increased social security benefits and health care costs is manifested by the need for congressional hearings such as this one. Inevitably, growing numbers of elderly will force dramatic changes in health care.

The burgeoning impact of nursing home care on the state's Medicaid budget is due to the fact that, for all practical purposes, Medicare does not cover nursing home care in South Dakota. Many people quite mistakenly believe that their Medicare benefits will help them pay for nursing home care should they ever need it.

Unfortunately--and as many elderly in need of nursing home care have harshly discovered--that is not the case. In fact, only 16 of the state's 116 nursing home facilities are certified to receive reimbursement under Medicare. The only other way in which nursing care is covered under Medicare is through hospital "swing" beds, of which there are approximately 444 such beds located in 29 hospitals across the state. In either case, a prior hospital stay of at least three days is required (with a deductible of $592) in order to receive Medicare benefits, which then covers only the first 20 days of skilled nursing facility care. Following that, the cost is $74 per day for the next 80 days, with no coverage after 100 days.

As a result, most elderly South Dakotans in need of nursing home care must consume their own financial resources to pay for their care, and in most cases ultimately seeking eligibility for Medicaid when those resources are exhausted. On average, over half of all private-pay patients in South Dakota find themselves seeking Medicaid within the first year of admission to a nursing home.

In order to alleviate the devastating impact that nursing home care can have on a spouse's ability to continue living in the community, the state implemented a "spousal impoverishment" provision in July 1989 which allows the spouse of an nursing home patient to protect a portion (up to $60,000 in resources) of the couple's income and resources when determining Medicaid eligibility. The net effect of this provision is that persons entering nursing homes with some resources becomes eligible for Medicaid earlier, and the family has less money available to offset nursing home payments which then correspondingly increases the state's Medicaid payment to the facility.

Since its inception in 1965, federal Medicare policy has, in effect, delegated the responsibility of providing long term care to the state. These policies have forced the state's Medicaid program to bear the cost of nursing home care for individuals who should rightfully be entitled to such care under Medicare. This responsibility should appropriately be assumed by Medicare, along with an ample floor of financial protection to ensure that no one faces impoverishment as a result of their need for nursing home care.

Recommendations. To that end, the State of South Dakota and the Department of Social Services makes the following changes in Medicare policy:

1. A mechanism should be established to allow State Medicaid programs to recover the costs of nursing home care provided to those individuals who would otherwise be eligible for Medicare.

2. The Department of Social Services concurs with the Pepper Commission's recommendations to establish a Nursing Home Program (NHP) which would entitle all nursing home users to "social insurance" for the first three months of nursing home care so as to allow people who need short stays to return home with their resources intact.

   At a minimum, provisions of the Medicare Catastrophic Coverage Act of 1988 which would have provided coverage under Medicare for the first 100 days of skilled nursing care without prior hospitalization (prior to the Act's repeal) should be restored. Current provisions providing Medicare coverage for only the first 20 days of skilled nursing care with a prior hospital stay fail to provide adequate coverage for the individual and significantly impact the state's Medicaid program when that coverage is exhausted.

3. Federal policies should foster incentives for continued development of alternative community-based long term care services as an integral component of a national long term care system, and in which the role of nursing homes in the continuum of care is to serve as significant health care facilities providing appropriate skilled nursing care.

4. To ensure adequate funding for these proposals Congress should consider raising income threshold on which Social Security taxes are paid.

IV. Conclusion.

Long term care in South Dakota is an important part of the state's commitment to the highest quality of life for all its citizens. Caring for the elderly will become one of the most important health and social issues in the next 20 to 40 years as the number of people needing long term care continues to increase and the cost of providing that care rises dramatically.

The nation's need for comprehensive long term care system which provides a continuum of appropriate services creates an urgency to explore new ways to care for people with long term care needs, and in the ways to fund that care. Government, providers and consumers of long term care are all recognizing that the present system is not structured to meet the long term care needs of an expanding elderly population. Without careful planning, cost issues will overrun the state's and the nation's ability to provide adequate and appropriate long term care in the future.

LONG TERM CARE FOR THE ELDERLY

Long-term care in South Dakota is an important part of the state's commitment to the highest possible quality of life for all its citizens. Many persons in the field of long-term care for the elderly believe it will be one of the most important health and social issues to be dealt with in the next 20 to 40 years because two things are happening simultaneously: the number of people needing long term care is increasing rapidly, and the costs for providing such care are growing dramatically. This creates an urgency to explore new ways to care for people with long-term needs and in the methods of funding.

Over $100 million are spent on nursing home care in South Dakota annually. Some measures for dealing with these costs would entail changes in long-term care that include preadmission screening, development of alternative care services, and a moratorium on construction of new nursing home beds. More changes in the delivery and reimbursement of long-term care are expected as the elderly population grows amidst continued federal and state budget constraints.

Long-Term Care in South Dakota

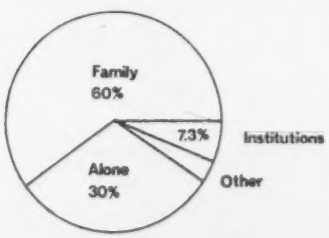
Long-term care services encompass the provision of health, social, housing and income assistance to the chronically ill and functionally disabled. Persons needing long-term care include the elderly (persons age 65 and over) as well as children and some non-elderly adults. Older persons by far are the largest group using long-term care services.

Most long-term care—between 80 and 90 percent—is provided by the "informal support system": family and friends of the elderly or disabled. Public financial support for this kind of care has never been provided.

South Dakota serves about 12,700 elderly persons with its long-term care services. The majority of these persons—7,700--are in nursing homes, and the rest participate in community and in-home service programs.

According to the Department of Health, over 7.3 percent of South Dakota's elderly population live in nursing homes compared to a national average of five percent. This rate is partly a result of the high number of nursing home beds per 1,000 persons over 65 and partly a result of the high number of people over age 85. South Dakota ranked in the top three states in the nation in 1985 with 84 beds per thousand elderly, compared to a national average of 50 beds per thousand elderly.

LIVING ARRANGEMENTS OF SOUTH DAKOTANS
65 AND OLDER, 1980



Institutional long-term care grew virtually unchecked for almost thirty years. National expenditures for nursing homes grew ten-fold between 1965 and 1980. South Dakota has gained over 7,450 nursing home beds since 1950 and the number of nursing homes have more than doubled from 59 to 136. A moratorium to prevent addition of new nursing homes beds would create an incentive to utilize alternative long-term care services and reduce the need to add to the state's long-term care system.

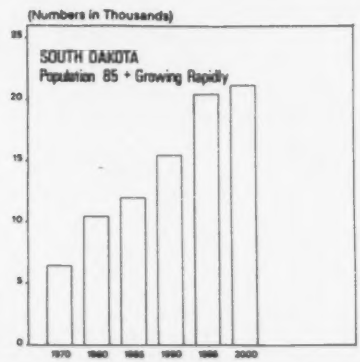
Alternatives to institutional care are being emphasized more and more as a less expensive option for persons needing long-term care. Preadmission screening can help prevent inappropriate admissions to nursing homes for those individuals able to stay at home with some services.

DEMOGRAPHICS

The first of the "baby boomers" will reach retirement age just after the turn of the century.

The generation now reaching senior citizen status (65 and older) was born in the early 1920s, a time of relatively low birth rates. **In twenty-five to thirty years, however, the "baby boom" generation of the late 1940s, 50s and early 1960s will begin to reach retirement age and dramatically inflate both the proportion and numbers of elderly.**

South Dakotans are long-lived. The state ranks 6th in the nation with almost 14 percent of the population age 65 and over. Since 1980 the number of elderly 85 and over grew 9 percent compared with 2 percent for the state as a whole. The number of people 85 and over is expected to increase 25 percent by 1995. Average life expectancy is 75 years.



Persons 85 and older are the most long-term care dependent. More than 32 percent of persons in South Dakota over age 85 were in nursing homes; 80 percent are over age 75.

Elderly veterans comprise about 14 percent of South Dakota's elderly population. As World War II veterans reach retirement age, however, the proportion of veterans in the elderly population will double by the year 2000.

About a third of urban elderly and a fourth of rural elderly live alone. The majority of these are women living alone.

Family size is shrinking. More couples are having fewer or no children. It has been estimated that half of the nation's families have no children under age 18 living at home.

Informal support is the most important component of long-term care--and one of the most threatened.

Smaller family size could have a serious impact on the availability of adult children to care for an elderly parent in the future.

The number of working women has grown steadily, and women are returning to work sooner after having children. More than half of the mothers in the nation who have babies return to work before the child's first birthday. Older women, too, are joining the workforce in increasing numbers, particularly women age 45 to 64.

As more families become dependent on two incomes and fewer women opt for full-time homemaking, the availability of at-home caregivers will diminish. The informal support system will be strained to adapt to the increasing care needs of the elderly population and the financial realities of the caregivers.

LONG TERM CARE ISSUES

Mental Illness: National studies indicate that 15 to 20 percent of the elderly in the community have moderate to severe mental illness, and 50 to 65 percent of the elderly in nursing homes have serious mental health problems.

At least half of the major mental disorders of old age can be attributed to physical causes such as Alzheimer's disease. The number of persons with Alzheimer's is projected to double by the year 2000.

Growth in the number of persons with serious organic mental disorders needing institutional care will further emphasize the need for alternatives for elderly persons whose mental problems are not directly related to a physical cause. Mental health strategies for the elderly which emphasize early intervention to prevent mental deterioration will be increasingly important to help people stay at home and out of nursing homes.

Poverty: Poverty often associated with old age is related to a number of factors, including retirement, the loss of a spouse and income from that spouse, and increasing dependence on Social Security. Analysis of the 1980 census reveals that 18.5 percent of the elderly live below poverty level, and poverty is higher for rural elderly. Median income of one-person households is usually lower than elderly married households, with single elderly women renters tending to have the lowest median income of all. Although recent indicators seem to show the elderly to be better off economically in the last few years, concern should still be raised for the very old, for those dependent on Social Security, and for elderly women.

Housing: A full range of housing options, such as shared group residences, accessory apartments, home improvement loans and grants, subsidized rental housing, and home sharing programs--is an important part of preventing the elderly from entering a long-term care institution as their only option when they can no longer live unassisted.

Successful development and implementation of alternatives to nursing home care is critical to the future of the long-term care system.

Alternatives: Improving the quality of life for the elderly and delaying nursing home placement depends a great deal on the availability of in-home services. South Dakota has begun to emphasize alternatives to institutionalization for persons at risk of nursing home placement. Alternative long-term care services include case management, adult day care, respite care, homemaker services, home health aides, adult foster care and personal care.

In 1987, almost 5,000 persons were served by alternative long-term care services. Most users of alternative long-term care services are females living alone.

In-home and community care options may turn out to be essential services for the elderly and not just alternatives to nursing home care

A 1987 study of Minnesota's long-term care alternatives by the Wilder Foundation found that in-home and community services play an important role in enabling the frail elderly to return home after hospitalization, rather than being discharged into a nursing home. National experience with alternative services is finding, however, that home and community services are developing as a part of the continuum of long-term care rather than acting as a substitute for nursing homes. Alternatives may come to be regarded as a new and necessary service for the elderly, rather than an effective means of reducing nursing home expenditures. Regulation and consumer protection become even more difficult with an increasing amount of home-based care.

Geographic access to long-term care: Most people would prefer to remain in their home communities when they need long-term institutional care. Some rural areas of South Dakota have been experiencing higher nursing home occupancies than urban areas for several years, and rural residents may have fewer options for nursing home care. The State Departments of Health and Social Services will continue to address the issue of the distribution of nursing home beds statewide in the future.

Increasing emphasis on alternatives to nursing home care is focusing greater attention on availability of alternatives in rural areas. More thought will need to be given to the role of in-home and community services in the continuum of long-term care for rural health care consumers.

Case management: With growing emphasis on alternative care and avoiding inappropriate nursing home placements, effective coordination of services will grow in importance and ultimately require development of a case management system. Case managers guide the client through the maze of multiple alternative community and in-home services, nursing home options, and funding sources. Debate over case management is now focusing on its cost effectiveness and the ability of case managers to remove persons from an inappropriate nursing home placement. Case management is a critical part of the developing alternative care system but is likely to remain an issue until more experience demonstrates its effectiveness or ineffectiveness.

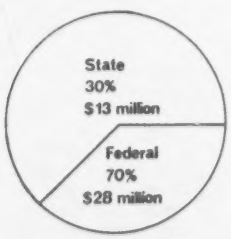
Eldercare: **More employers must begin to recognize that care for an elderly relative is a pressing concern of many employees.** Up to 25 percent of employees in companies with an average employee age of 35 or more may have significant caregiving responsibilities. The majority of caregivers are women, and, according to some studies, almost half of all caregivers find that coordinating care for an elderly relative takes time away from work. As more older women enter the workforce, the number of employee caregivers is expected to grow.

THE COSTS OF LONG-TERM CARE

The average cost of staying in a nursing home in South Dakota, across all levels of care, is about $45 per day, or almost $17,000 per year per person.

The State Medicaid Program pays for over half of all nursing home care costs, and the rest is paid for by nursing home residents themselves. To qualify for Medicaid persons must first deplete most of their assets, or "spend down" to an eligible level of income. The majority of all private paying nursing home residents eventually become eligible for Medicaid.

CONTRIBUTIONS TO MEDICAL ASSISTANCE FOR NURSING HOME EXPENDITURES - FY 1986



How to pay for nursing home stays is one of the biggest health issues facing policy makers, care providers and consumers of long-term care.

State payments to nursing homes have increased 2 1/2 times in the last ten years. South Dakota spent $17.8 million in payments to nursing homes in 1978, and almost $41 million in 1987, or over 42 percent of its Medical Assistance budget. The state portion of Medicaid is about 30 percent, or $13 million.

Funding for alternative services is expected to grow as programs develop. In 1982, the state spent just under $2.5 million per year. Spending in 1987 was $3.7 million, less than 10 percent of the amount spent on nursing home care. The average expenditure on alternative services per person in 1987 was $67 per month, or $798 per year per person. This includes federal, state, and local funds.

The question of how to finance the staggering cost of long-term care is of growing national concern. **Even with the growth of alternatives, some feel that national expenditures for care in nursing homes could quadruple by 1990.** Emphasis is now being placed on the development of cost-saving options for financing long-term care.

The fastest growing cost-saving option is private long-term care insurance. Long-term care insurance, however, is not viewed as a source of long-term care financing for the low-income elderly, but as a means for persons with assets to protect those assets from the catastrophic costs of long-term care, particularly the "spend down" associated with nursing home stays.

Suggestions for developing long-term care insurance include providing tax incentives to employers, promoting private section innovation, and exploring the potential of home equity conversion to finance long-term care insurance. Concerns about long-term care insurance include variation in the comprehensiveness of coverage being offered; increasing disparities between those who can afford long-term care insurance and those who cannot; and over-encouragement of home equity conversion which might result in the elderly unnecessarily losing their homes. Development of insurance policies for long-term care has been slow in the state so far. Nationally about 400,000 individual long-term care policies have been sold.

Implications

The need for long-term care is likely to increase well into the next century. Government, providers, and consumers of long-term care are all recognizing that the present system is not structured to meet the long-term care needs of the expanding elderly population. More emphasis is being placed and will need to be placed on creative approaches to care for the chronically ill.

The rapid growth of the extreme elderly (85 and over) population makes it clear that maintaining nursing home populations at their present level will require substantial reductions in the rate of institutionalization.

Without carefully planning, **cost issues may overrun quality-of-life issues in the next few decades** and limit the state's ability to provide adequate and appropriate long-term care in the future.

The previously generous provisions of funding for nursing home care and lack of compensation to families for informal care led to an over-emphasis on institutional care for the dependent elderly. **Now that government has realized that spending for nursing home care must be limited, a means of encouraging informal care providers, including financial compensation, will need to be found.**

National studies indicate that even with the development of private options such as insurance, financing long-term care is likely to remain a critical public issue.

Each aspect of long-term care--nursing home care, community and in-home services, and case management--will continue to be scrutinized as to its cost effectiveness and its place in the continuum of care throughout South Dakota.

The aging of the population and the tightening of federal and state budgets will contribute to the polarization of society between the very young and the very old. Competition over scarce finances to service these vulnerable populations will create a challenging situation for policy makers and care providers. Effective long-term care solutions will be the result of a carefully achieved balance between society's values and the real financial constraints of national, state and local governments.

Senator PRESSLER. Incidentally, anyone here who wishes to submit written testimony is welcome to do so. We will have time for some questions afterwards. By the way, I should just give a salute to our stenographer, Amy Johnson. She doesn't expect to be introduced, but she's right over here. Give her a hand. She's recording this in a summary that will be circulated among the Senators. Next, we will hear from Dr. Bob Schmidt of Marion, with the Tieszen Clinic in Marion. He will provide firsthand information about health needs of the elderly.

STATEMENT OF DR. ROBERT SCHMIDT, CHIROPRACTOR, TIESZEN CLINIC, MARION, SD

Mr. SCHMIDT. Thank you Senator Pressler, Congressman Johnson, members of the panel, and I think it is so aptly stated, the expert witnesses are out in our audience. It also makes you feel like you are not an expert sitting up here because we cannot truly say what some of the problems are until you've actually lived them and experienced them. My mother, incidentally, is in a nursing home so I am aware of some of the problems that exist with nursing home problems. I've been asked by Senator Pressler to expand on some of the things that we as chiropractors feel should be included in Medicare coverage. Presently, the Medicare coverage of chiropractic services is as follows:

First of all, it is mandatory that an X-ray examination be made of the patient to demonstrate a subluxation which will qualify that treatment for Medicare consideration. However, the bad part of that is, the patient is required to pay for the X-ray.

Number two, office visits. An elderly patient is entitled to 12 office visits per year. However, there are certain exceptions to that. You can submit a treatment plan and then sometimes that number is extended. Incidentally, on the required X-rays they are also required to be repeated every year.

Modalities. Medicare does not cover any modalities which are used by a chiropractor. Medicare does not cover any of the treatment performed by a chiropractor that are, other than the spine-related problems, such as a knee or ankle sprain.

Examination. Medicare does not cover any type of an examination performed by a chiropractor.

I feel very strongly that the Medicare reimbursement policy can be arbitrary and unfair, and in fact, often acts as an impediment to the goal of improving access to quality health care for patients.

The decision for the mandatory X-ray examinations are not always based on clinical necessity. This can cause unnecessary patient exposure to radiation when the treatment may have been done and performed without the required X-ray.

Senator Pressler, Congressman Johnson, I feel the following changes should be made in the Medicare Act as it relates to chiropractic services for our elderly:

First of all, I think they should discontinue the mandatory X-ray requirement. However, if the X-ray examination is performed by a chiropractor, I believe that service should be paid by Medicare on the same basis as it is with the rest of the allied health fields. I think all examinations, either X-ray or physical, should be paid by

Medicare. The mandatory X-ray does not allow the elderly patient the freedom of choice of practitioners. They must either pay the bill for the X-ray exam or seek their services from a medical doctor or a doctor of osteopathy.

I'd like to just give an example of the nursing home facility that we have in Marion, and by the way, we have five active practicing chiropractors in Marion. We have two clinics in Marion. Both clinics have excellent X-ray facilities. We have on occasion, which happens quite often sometimes, where residents in our nursing home will have an accidental fall or an injury. Sometimes they are brought to our clinic for examination, and especially X-ray, which is usually required, and they either have to pay for that themselves or travel 15 to 35 miles to receive the same care, which I really consider an unjust thing for the patient and it does add an increased cost for the patient to go to an extended facility. We can do the X-ray exam, and then refer the patient to a specialist if necessary. If it's a fracture, we work very closely with some of the orthopedic surgeons here in Sioux Falls.

Office visits. I just cannot understand why an elderly patient should be restricted to 12 office visits per year when no one else is. All the health insurance coverages that cover chiropractic care have no such restriction.

Most elderly conditions are chronic in nature and require more care. The individual can be relieved by manipulation, kept active longer, and often requires less assistance by other personnel, such as nursing home residents.

I do not feel that chiropractic care should be restricted to the spine only. I think all the services provided by a health care practitioner, if within the scope of his practice, should be covered by Medicare. A good example of that: Recently, I X-rayed three Medicare-age people in Marion that had fractured the upper bone in their arm, found it to be completely fractured and impacted, which is probably one of the easier fractures to maintain and take care. Of those people, one of them decided to go to Sioux Falls and be treated by an orthopedist. The other two were sent to one of the orthopedists in Sioux Falls for evaluation, consultation on continued care and treatment, was referred back to me to be taken care of. However, the person had to pay for that themselves. I don't really believe that that's very fair, plus it forces the elderly patient to travel back and forth to Sioux Falls when they could receive the continued care which they would need right in Marion.

In conclusion, chiropractic care has been proven to be cost effective, and the total chiropractic services of the Medicare Act is only one-half of 1 percent of the total Medicare budget. I don't believe adding money to the Medicare Program is going to solve our problems. I think we have to make use of all the professional and not be restrictive. I think duplication of procedures—and perhaps that's happened to some of you here. You will be examined very thoroughly and properly by one of the medical people here in Sioux Falls, perhaps referred to Mayo Clinic, or any other facility, and they run all the same tests, whether it be a CAT scan, MRI, or whatever it may be. They duplicate all the services and cost Medicare twice as much.

I think it's time that we lay aside all the professional egos and become concerned about you, our elderly people, instead of our own personal images.

Most small towns have a nursing home. Most small towns have a chiropractor who is well trained in X-ray and examination procedures. I think we ought to make them available to you, the elderly people. Thank you, Senator Pressler.

Senator PRESSLER. Kathy Nickelson is a registered nurse and works at the Human Services Center in Yankton. She works with the elderly in the Gero-Psychiatric Unit. Kathy will share her experience and make her recommendations. Kathy, thank you for being here.

STATEMENT OF KATHY NICKELSON, LICENSED PRACTICAL NURSE, HUMAN SERVICES CENTER, YANKTON, SD

Mrs. NICKELSON. Thank you. Good morning panel members, as well as Tim and Senator Pressler. My name is Kathy Nickelson. There is an error, however; I'm a licensed practical nurse not a registered nurse. I am licensed in South Dakota. I've been in the gerontology field for 15 years. I work at the Pierce Nursing Home Unit, at Human Services Center, and I also am a senior at the University of South Dakota in political science, but my interest is health-care legislation. I am speaking totally on my own behalf and opinions as I see needs being in the gerontology field from my 15 years of practice in that field.

Our population is becoming older. We are now living longer than ever before. We've made advances in health care, developing new technology and treatments for diseases never imagined possible. Unfortunately, with all of these developments, one field that is constantly being overlooked and lacking new developments and funding is the field of gerontology.

One of the problems encountered is a lack of funds to help nursing homes and institutions give the quality care the elderly are entitled to today. They are forced to increase the cost of rates and fees connected to nursing home care to provide minimal services and lack funding for full staffing of their unit. It is a known fact that nursing homes are the lowest paying of health institutions and have a high turnover rate of employees. The work is hard. A lot of lifting of patients and daily care being given. That's a very tedious task. Hours are long, stressful, with constant exposure to physical and mental abuse. Every nursing home I have been associated with in gerontology, I have found the same problem prevalent. The moneys simply aren't there to maintain quality staffing resulting in quality care. For example, at Pierce Unit that I work at, we have a current shortage of 15 aide positions, 5 staff nurse positions, and a turnover rate of approximatley 25 percent after 1 year of employment, and our situation is not unique. When we have staffing shortages, everyone suffers—the staff is committed to overtime, few days off, and stress becomes greater and tempers shorter with one another and quality care per patient is just not possible. As a result, staff becomes burned out, quit, they leave the institution with one less employee. Most elderly institutions are forced to go to

a 12-hour shift to give adequate coverage for the patient. We're simply in a crisis situation.

We at Pierce Unit have some activities of daily living, or ADLs, as you are probably aware, such as ambulating patients, that cannot be achieved because we are always short of staff.

No longer should a person have the stigma that because they work at a nursing home and not a hospital they should expect low wages. Institutions that keep wages low lose staff and have to depend on current staff for overtime which does not save money when you are paying people at time-and-a-half wages. For example, at Pierce Unit alone, we will be paying out approximately $60,885 for 7,748 hours of overtime. That's a lot of money.

Nurses' aides are expected to complete a certification course of 75 hours and testing to become certified. The course is not easy and takes away floor time from that aide.

The nursing homes or institutions for elderly that do not recognize the value of the nurse and/or nurses' aide cannot increase wages because of inadequate Medicare funding. The public should be aware that care expected to their elderly family members suffers when adequate Medicare funding is lacking and staff shortages are at critical stages. Too long people in all areas of elderly care are criticized as being an inadequate caregiver when, in fact, the Government remains complacent in Medicare funding.

Another area of elderly care that suffers is home care. I have a neighbor whose father is a chronic emphysemic. He's on oxygen therapy 24 hours a day. He's alert, oriented, not a rich man, and he's not certified for nursing home care in any other way, yet he needs someone with him 24 hours a day. He can't afford to hire a nurse privately and is currently seeking a county nurse to come to his home two to three times a week and it is a terrible effort even to get to a hospital for respiratory therapy or check-ups. His medical insurer refuses to pay for home care, and Medicare will not pay for it at all. The rest of the time is spent by my neighbor, his daughter, taking care of him, plus, she's trying to bring up five children of her own and take care of her own home. To them, a nurse would relieve a lot of pressure encountered in this situation and give them the satisfaction of his being well taken care of in his own home. It has been stated that Federal funding to community or nursing homes is to be cut. If that is done, why not put funding toward home care? It would be cheaper and allow the person the dignity of being in his own home.

Psychogerontology nursing is another area of need regarding inadequate funding and staff shortages. To be admitted to our unit, you have to have a mental illness diagnosis. You must be over 55 years of age, and we see increasing amounts of admitants needed. We have several elderly patients we see admitted for severe depression. Often a lot of them come from other nursing homes to us for care for a period of time, and then when we make them better, they go back to their nursing home. Costs for care of patients on our unit is best shown by some figures that are shown on Pierce One, which is our skilled floor—nursing home floor. Current physical conditions of our patients. We have 75 percent that must be bathed, dressed, toileted, lack bowel and bladder control, and are confused or disoriented. Fifty percent receive rehabilitative serv-

ices. Forty percent are demented, including Alzheimer's disease. Thirty percent are manic depressed or depressed. Twenty-five percent are schizophrenic. Minimum staffing requirements are two nurses and six aides—we usually work with only four—on shifts until 11 p.m. when one nurse and four aides are present. We usually end up working with 3 for the care of 40 patients per floor. As you see, the ratio of patient to caregiver is poor. You're looking at approximately 1 aide for 10 patients.

Medicaid and Medicare certification is in jeopardy. Very few, if any insurers will pay for mental health care at all. Unfortunately, mental health care seems to be an issue we put over here, and yet it affects everybody of every age.

We at the Unit work hard to get our patients functional to return to the home or nursing home. Unknown to the public, we also strive to achieve these goals with one-to-one visitation, functions within the facility for their psychosocial needs, but lack of staff in recent months has made our care and goals for the patient difficult to receive. If adequate funding is expanded to elderly institutions, the goals and standards people expect to have given and to receive can be achieved. We are not a rich State and our people cannot afford expensive health care. Funding available for proper staffing and wage levels that health caregivers deserve, funding for in-home programs for home nursing care and rehabilitation, will insure we, who are in gerontology, the satisfaction of getting a job well done with the proper tools to achieve our goals.

Because we are a Nation and State that have increasingly older populations, it is our duty and obligation to provide them the best care possible. One answer could be to set up Medicare payments for the type of disease and whether it is of long duration. Second, funding must become available for mental illness. It is becoming more common among the elderly as well as the young. Too long it has been ignored, and families have lost everything in providing care for their mentally ill loved one. It is dispicable that we do not allow for coverage of mental illness. Let us start putting priorities in critical health issues and face our responsibilities and facts of health care. We owe our elderly and families that. Thank you.

Senator PRESSLER. The next speaker is Lil Norlin Kleinsasser whom I know has done a lot of work. I must say, first of all, that in regard to Kathy Nickelson's fine statement, that I have two sisters who are registered nurses. I know how hard they work and how much of a contribution they make—registered nurses and others. We're very lucky in South Dakota to have the dedicated personnel that we have in our homes. I would also—I've also been asked to say that there are copies of the Pepper Commission recommendations for long-term care. They are out on the table by the door, and I would also add in listening to all of these various speakers that there is also a budget summit going on. There is the summit between Gorbachev and Bush, but there's also an ongoing budget summit in Washington. We're now struggling with the Federal budget and will be until September, so as I listen to this, I'm taking back ideas for priorities in that budget. In any event, I'm going to call on Lil at this time to share with us what is on her mind this morning, Lil.

STATEMENT OF LIL NORLIN KLEINSASSER, ALZHEIMER'S ASSOCIATION, SIOUX FALLS, SD

Mrs. KLEINSASSER. Thank you, Senator Pressler. Recently an issue of the AARP Bulletin carried a story with the title, "Matter of Life and Death. Supreme Court Soon Will Rule on Who Can Decide." I would like to direct my statement to the question: What are my rights in choices of medical care, and how can I insure that I will not be kept alive indefinitely should I become terminally ill or in a comatose condition with no known hope of any recovery to a life of some value? Who has the right to decide whether I should continue to exist only by artificial means? Is it right for the law or the court to intervene or disregard the oral and/or written statement of a loved one who has expressed the wish that extraordinary or mechanical means should not be used to extend the heartbeat?

My mother who died at 76 years of age following surgery was recovering when complications began. Procedures were taken to try to correct the unexpected crisis. Then she told me, "I am going home on Wednesday," and I answered, "Yes, Mother, if the doctor gives you permission." Two days later she said, "I hear a choir singing. I want to sing with them," and on Wednesday she did go home, to her heavenly Home. She was given oxygen to ease her breathing those last few hours.

A beloved professor who taught and encouraged many medical students died a few years ago in a California hospital. The doctor who attended him those last days wrote a letter to the family from which I would like to quote a few statements. He is a doctor in cardiology, diplomate on the American Board of Internal Medicine and Cardiovascular Disease, and a Fellow of the American College of Cardiology. These are his words:

> Although I realize that words are of little value in difficult times such as these, I want to extend my sympathy to you and your family on Dr. Strunk's death. Despite the outcome of his recent hospitalization, I continue to believe that the proper decisions were made concerning the management of many medical problems. From a heart standpoint, it was obvious that he had a severe disease that no longer responded to any available medication or therapy. I am suspicious that much of the irregular heartbeating was related to the lung tumor, which was most certainly malignant, and was growing into the heart area. The tumor would also explain his recent weight loss, coughing spells, and lack of energy. Although I do not believe that heroic continuing medical measures would have been at all successful, I wholeheartedly concur with the humane decision not to try to extend his life which clearly would have consisted of further slow determination and suffering.

So far the doctor's statement.

Our Siouxland chapter of Alzheimer's disease has a personal story in the 1989 quarterly issue of our publication written by Mr. Mike Monseur, anchor-reporter for KSFY Television, Sioux Falls. I am sure many of you have become acquainted with him through his position. His father, in his early 50's became forgetful, weak, and dependent on others. Mike saw his father, a bright strong man, becoming a shell of helplessness. As his father continued to deteriorate, he watched his mother deteriorate as well. The day his father died his mother called Mike and said, "You better come home." Mike walked into the room and saw the nurses, his mother, and sister beside the bed. When his father heard Mike's voice, he perked up, smiled at his son, and said, "Miss me, but let me go." Then so peacefully, he lay back as if he were resting. Mike thought

everything was okay, but his mother looked at Mike, not with tears, but sharing his dad's happiness she said, "Dad's gone." Mike couldn't cry. He didn't know what to do as they took his dad away. What consoled him in his time of confusion were his father's last words. "Miss me, but let me go." This is the title of the poem his dad gave to a friend to give to the family at the time of his death.

When I come to the end of the road and the sun is set for me I want no rights in a gloomfilled room. Why cry for a soul set free? Miss me a little, but not too long, and not with your head bowed low. For this is a journey we all must take, and each must go alone. It's all a part of the Master's plan, a step on the road to home, and bury your sorrow in doing good deeds. Miss me, but let me go.

I believe many of us would wish for such a death with dignity. So again, the question: Is it right for the law or the court to intervene or to disregard the oral or written statement of a loved one who has expressed the wish that extraordinary or mechanical means should not be used to extend a life of helplessness?

Senator PRESSLER. Morris Magnuson was senior intern for me in 1988. I have a senior intern every year to advise me on some of the issues facing senior citizens, not only in this area, but also in Social Security and other matters. I addition, Morris is a good friend of mine. He is a member of the South Dakota Retired Teacher's Association. He's very active in senior activities, and we now call on Morris Magnuson.

STATEMENT OF MORRIS MAGNUSON, ACTIVE PARTICIPANT IN SENIOR ACTIVITIES, SIOUX FALLS, SD

Mr. MAGNUSON. Thank you, Senator. I appreciate that, and I'm really pleased and honored to take part in a presentation such as this. I really don't feel too much like an expert, though, except that I have lived past 65 a pretty good way, I guess, of becoming an expert. Addressing long-term care certainly is a wise move and one that is very necessary. It concerns everyone in our country, not only our elderly but also the coming generations who are going to have to share in some of the long-term care costs for their parents, and in some cases we have younger people who are in nursing homes because of disabilities. It has been mentioned here, of course, I have heard of some of the problems that are concerned with the rising costs and the different factors that enter in and it's going to become more and more critical. Senator Pressler mentioned the fact that the number of elderly are going to double here by the year 2020, and we're going to find a greater and greater problem, one that must be addressed.

I think that in many cases we have to avoid the institutionalization as much as we can and go to other areas of care for our elderly. My own mother died just a month ago at the age of 93, and of course, I grant you she was blessed with good health and lived in her own house, and later in an apartment, on her own up until the time that she died and was never in a nursing home. She died in Washington State, but the thing that really kept her going in her own home was an aide who came in 3 days a week to assist her and help her in her daily living and allowed her to remain independent and active right up until the time that she died. Her Saturday morning bread parties were a part of that neighborhood, and she would get up every Saturday morning at 5, bake bread, and serve

anyone who would come, and this I think really kind of kept her going and kept her young. But it is a way of subsidizing and helping these elderly with a very nominal cost which we certainly have to look at, and there are only so many dollars to go around.

My wife and I both deliver Meals on Wheels, and here again is a program that enables people to get that one good meal a day, and in many cases, it is a matter of getting that or making some other arrangements which, perhaps, could be nursing homes. It is done in cooperation with other agencies and the Federal dollars that are spent on that are very minimal compared to other programs and certainly well utilized.

There are some other programs such as day care. We do have a day care here in the Bergeland Center, of course, that enables many people, here again, to stay in their own homes or the homes of their children and be taken care of during the day. In yesterday's Argus Leader, we noticed that First Baptist Church is considering a program of that same nature and hope to get that expanded and going there. Many other organizations are senior centers, and the churches, of course, do much to keep the elderly active and involved and independent, and I think it is so important that we advance both medically and socially to develop ways to keep our growing numbers of elderly living independently and happily the last year of their lives. I know that some people just can't afford—or they can't avoid being in a nursing home with some of these people that are here at the hearing this morning, but I'm sure that most of us would want to avoid that as much and as long as we possibly can.

I think another area that should be addressed very carefully is a look at a national health care system, perhaps one similar to Canada's. While their system may be kind of weak in some ways and has some disadvantages, it certainly does have some advantages in the fact that a Canadian can walk into a hospital or a doctor's office, and all they need is a card. There's no billing. There are no deductibles and no hassle. I think that this is something that our country has to look at. We're spending more money now per person than Canada is, and we still have 37 million people that are uninsured or underinsured, and of that number, about a third of them are children. It is certainly a real discredit to our country that we can't take care of those people, and I'm sure that many of those are here in South Dakota. Many of the farmers that do not carry any insurance—it is so high priced, so costly, and here again, we've got to approach that problem and see if that can't be resolved in some way or another similar to some of the foreign countries or to Canada. Many of the European countries, of course, have had coverage like that for many years. I think another thing that we have to do as a society is to promote healthy lifestyles and physical activity that will result in happier, more enjoyable life. I think we're all well aware of the cost and the problems that are caused by smoking and drugs and alcohol. The elderly who most enjoy their days or their later years are those that are able to remain active and involved in many activities, and we'll have to do more and more to keep them in that particular way.

So Senator Pressler, let me urge you to very seriously look at action to bring about health-care reform to address the needs of

our uninsured and to also pursue the alternatives to nursing-home care which will ultimately be less costly and more enjoyable to people in their final years. Thank you.

[The prepared statement of Mr. Magnuson follows:]

1305 East 54th Street
Sioux Falls, SD 57103
May 23, 1990

Senator Larry Pressler
407A Russell Senate Office Bldg.
Washington, DC

Dear Senator Pressler,

I would like to submit the following testimony for Senate Aging Committee hearing to be ehld at Prince of Peace Retirement Center in Sioux Falls on May 29, 1990.

Long Term Care is an issue that concerns everyone in our country. It is predominantly the elderly that need it but it impacts other ages when financing is involved and, in quite a few cases, when younger people become disabled and must resort to nursing home care.

This is becoming more critical each year with life expectancy moving upward and our World War II veterans in their 60's, 70's and 80's. I notice that your committee has estimated the number will nearly double by the year 2020.

Unnecessary institutionalization should be avoided-it just seems logical to care for a person in their own home, with some care giving assistance, or in a board and care home-as long as it is at all feasible. My own mother died a month ago at age 93. Granted, she was blessed with relatively good health all her life but without a caregivers help three days a week the past eight years it would have been very difficult if not impossible for her to continue living in her own private apartment. In addition to being much more economical, it allowed her to be independent and to host her Saturday morning bread parties right up to the time of her death. She enjoyed having many friends call and delighted in entertaining them-the coffee pot was always on!

This was accomplished with a very minimal dollar outlay and also furnished a job opportunity for a person that could otherwise be unemployed. Home care, for those who are able to care for themselves to some extent, is certainly a desirable and sensible way to go when one considers the social aspect and the cost, which would probably be a fifth of the cost of a nursing home.

My wife and I deliver meals-on-wheels to many people-both in homes they have occupied for many years and in apartment complexes for the elderly. Here, again, a minimum investment by the government (local, state and federal) coupled with private contributions and volunteers keep these people functioning happily in their own familiar surroundings as long as possible.

Senator Pressler.. continued..

There are other programs, such as day care, senior centers and church activities, that keep elderly active, involved and thinking healthy at very advanced ages. It is so important that we advance medically and socially to develop ways to keep our growing number of elderly living independently and happily the last years of their lives.

We need to look at several other areas of health care. First, we should very seriously consider a national health care system similar to Canada's. While their system may be weak in certain areas-not as advanced in technology and procedures as the U. S., delays in elective surgery and not as much flexibility in doctor selection- it does have great merit. All a Canadian citizen needs is a card! And there is no billing, no deductibles, no hassle. This would be great for our 37 million (many of them children) without health insurance of any kind. It would eliminate problems with Medicare, Medicaide, Medigap premiums that keep climbing.

Secondly, we should more actively promote healthy life styles and physical activity that will result in a happier, more enjoyable life. Our problems with smoking, alcohol, drugs, and a society that is too well fed (to the point of being overweight) should be addressed.

The elderly who most enjoy their latter years are those who exercise and remain active and involved in many ways. There are many factors over which we have no control when it comes to health, but there are certainly many that we do have control over!

Let me urge you to very seriously look at action to bring about health care reform, to address the needs of our uninsured and to also pursue the alternatives to nursing home care which will ultimately be less costly and more enjoyable for people in their final years.

Sincerely,

Morris W. Magnuson

Morris W. Magnuson
1305 East 54th St.
Sioux Falls, SD 57103
605?334-6862

Senator PRESSLER. Thank you very much. We have one more witness, and then we'll have some questions.

I might say during our questions, we would welcome Wayne Muth and Gary Tuschen up here also, if they want to participate in the question and answer.

I would like to welcome Bonnie Brown of the Evangelical Lutheran Good Samaritan Society—some of you may not know, but the national office is located in Sioux Falls. The Evangelical Lutheran Good Samaritan Society is the largest nonprofit organization providing nursing home and housing for the elderly in the United States. They serve 25,000 elderly, and I think they are located mainly in smaller towns and cities—and incidentally here today when I use the word "rural", we certainly include small cities and smaller towns, and we include cities such as Sioux Falls. So frequently our legislation in Washington becomes a battle between the large States and the small States, and some of the standards used in big cities where you have huge operations are different. So when I say, "rural areas, smaller cities and towns," I'm referring to all of South Dakota, but throughout America, even New York State, there are smaller cities and towns.

Bonnie Brown's organization is headquartered in Sioux Falls, and it is the largest nonprofit organization providing nursing home and housing for the elderly in the United States, so I think that's pretty impressive. Bonnie, could we hear from you?

STATEMENT OF BONNIE BROWN, VICE PRESIDENT OF THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY, SIOUX FALLS, SD

Mrs. BROWN. Senator Pressler, members of the panel, and community of interested persons. My name is Bonnie Brown. I represent our President Mark Jerstad and the Evangelical Lutheran Good Samaritan Society with its corporate office in Sioux Falls, SD. The Good Samaritan Society operates some 200 facilities in 26 States, serving over 25,000 residents in nursing homes and retirement villages with a staff of over 16,000 persons. Our organization is 68 years old and is the largest nonprofit provider of long-term care services in the Nation. My area of responsibility with the Good Samaritan Society as vice president of operations is working with 11 regional directors to oversee the day-to-day operations of the 200 facilities throughout the Society. I bring 19 years of experience to the long-term care field as a licensed nursing home administrator.

Let me begin by saying that I do not have an answer for how long-term care can be paid for. I can only tell you, as you well know, that the costs are increasing faster than the annual rate of inflation. Why? As a highly regulated business, the parameters in which we operate are extensive and varied. Most recent of these regulations, the Omnibus Budget Reconciliation Act of 1987, OBRA, which will take effect on October 1, 1990, stipulates that licensed nurses be on duty 24 hours a day and that an R.N. be on duty at least 8 hours a day. A welcome regulation, but who's going to pay for it? Another significant part of OBRA, as you've already heard, is that 75 hours of nurse aide training has to take place

before a staff person can begin to assume his or her duties in caring for residents. Again—a welcome regulation, but who's going to pay for the additional costs? The cost of providing this additional nursing coverage and additional nursing assistant training has to be included in the daily rate that residents must pay for. Added to this is the shortage of licensed persons, with the resulting wage wars that surface and the additional costs that get added onto the daily rate; and the gap between private pay and Medicaid reimbursement widens.

Another area with which I'm very familiar, having just completed a quarterly view of the Society facilities, is the matter of workers compensation. We are a very labor-intensive service—business, organization, and the care of residents requires much lifting and turning which can result in back injuries even though we have an excellent program of training our staff in transfer techniques. Worker's injuries cost dollars and costs add to the daily rate paid by nursing home residents, and the gap between private pay and Medicaid reimbursement widens.

The population is shifting in South Dakota and some of the other Midwest States. We have an out-migration of young people, and the elderly population remains somewhat static which results in a State with a higher than average proportion of older persons. For some of our smaller communities, the nursing home is the first or second largest employer in the town, depending on whether a school is located there. The nursing home employs a large number of single parents, usually mothers, at a wage ashamedly at or slightly higher than the minimum wage, currently at $3.85 an hour. To increase wage scales means that private-pay nursing home rates would have to increase because the State Medicaid system does not cover all costs. Nursing home income comes from two primary sources, private-pay residents and Medicaid residents. In the Good Samaritan Society, there is no discrimination or differentiation in the quality of care provided whatever the pay source.

In recent years, Medicare reimbursement utilization has slightly increased, and our present plan of action is to certify more of the Society facilities for Medicare, believing that this is one more benefit to the residents who qualify either in stretching private pay or the Medicaid dollars. Medicare as a Federal program is a mechanism, if the resident qualifies, that can provide dollars for long-term care for a limited period of time before private pay or Medicaid, a State-Federal program begins. We are faced with a dilemma: A declining rural population, a shortage of licensed staff, increasing training costs, increasing regulations, and a strong desire to continue to provide the best possible care for our residents—residents who have contributed so much to this State, residents who live in fear of exhausting their assets, or who have already exhausted them, residents who deserve our love, our concern, our care. At a time when costs are high, the allocation of national resources is being diverted to possibly bailing out the savings and loans. One commentator last week indicated that the dollars spent on solving the S and L crisis would provide health care for every man, woman, and child, including long-term care for 4 years. It would seem that the resources are available to address health care needs. It becomes a matter of allocation.

In conclusion, I regret that I cannot offer a magic solution to the concerns we all face. We at the Good Samaritan Society are ever seeking cost-containment measures. We are addressing all sources of payment, as I mentioned earlier, becoming involved again in Medicare. We have studied long-term care insurance for over 5 years as a consideration of how nursing home costs can be met. In addition, we continue to look to resource development to provide charitable gifts to assist in covering long-term care costs. None of these is an answer in itself. What we do know is that careers in long-term care are among the most rewarding, and the people we care for are a living history and we can learn from them. We know that people are living longer and are coming to the nursing home more frail with greater physical needs, and the question of finding some way of matching care and services with dollars begs to be answered.

I do want to assure you, Senator Pressler, that we welcome this opportunity to discuss rural health care, and we stand ready to assist in whatever way we can to assure our elderly people—that they need not face the future in fear of not being able to receive proper care if and when they need it. I thank you for this opportunity.

Senator PRESSLER. Now, we have about 15 minutes where we have to conclude this hearing to have some questions or comments from the audience, and I think it would be good if we would call on the expertise of Wayne and Gary if they were in the room. Also, if they want to respond to any of these questions. We do have some experts here. Does someone have a question or comment they would like to make? Yes. Go right ahead and if you could state your name for the reporter here and speak into the microphone. Thank you very much.

STATEMENT OF H.B. SHREVES

Dr. SHREVES. I'm Dr. Shreves, H.B. Shreves, Sioux Falls. I'm in my 50th year of being a physician. I was kind of surprised there were no physicians on the panel. I take that back, there was a physician up there, no medical physicians on the panel. I was the first board-certified surgeon in Sioux Falls. I have four of my family that are physicians, one son-in-law and three of my children. I have 11 lawyers in the family that take care of them. Six of them are lawyers, and they are married to lawyers, three of them.

I'm interested in this because I have somewhat of a plan, and I was glad that one person mentioned that we have no national health plan in this country. The only other civilized nations in this world that don't have one—the only other is South Africa, and obviously they don't have one because they don't want to take care of all those blacks. They would never have money enough to do that. I can solve your problems because I can see the problem is everybody that's talked so far, it all ends up with one thing. Money. Money. I have somewhat of a solution to this problem, but I can tell you one of the reasons why we can't compete internationally with Japan. Japan has a national health insurance and their manufacturers, their businessmen don't have to figure in this tremendous health insurance cost that the employees now have to have. The bargain-

ing today is done mostly over who's going to pay the health insurance figure that all of these large corporations in this country have. What a great thing if we could do what Japan done to relieve these national corporations—relieve them of this terrible burden, if we all paid in on a national health plan. The one we have now is—well, it's next to nothing. We keep patching it up. What we're doing here today, we're trying to go patch up something that doesn't work. It never has worked from the very start. The doctors quickly found out they could make a lot of money by doing—just avoiding the little turns and corners, and every time they make a law the doctors found a new way of getting around the law, and nothing has happened except the prices have gone up. Doctors' figures have gone up. Hospital fees have gone up, and the hospitals have always been ahead of the Nation and rise of cost figures.

I'm interested in what's happened here today, but I'm sure all of you realize that if the system continues on as it has—and one of the gentlemen mentioned the system in Canada. We can do much better than Canada, very much better than Canada. There are many more programs that are much better than the Canadian program. We have to remember we have the most expensive, the most sophisticated, the most advanced equipment—medical equipment in the world. We have the greatest—one greatest clinic in the world. The Mayo Clinic is the most known, I think, in the world, the most advanced of any medical care, as many of our large institutions are. Still we can't get this medical help to the people of the country, the 37 million uninsured poor that we mentioned. That number doesn't near touch the total number of uninsured people in this country, and probably you could add to this the poorly insured. I find now as a retired physician—I'm not really retired. I was teaching in the Medical School up until last July, and I still have two clinics at the Veteran's Hospital. Why can't we get orthopods to go out to the Veteran's Hospital and work? They will work out there for a while. They will advertise on the TV to get business, but they won't come out to the Veteran's Hospital and work because the pay isn't as much. The money factor has been the big thing, and I'm sorry to say that the doctors have been a big part in causing the rise of medical costs.

Senator PRESSLER. Thank you very much. You have filled in a very much needed gap here. We did have a physician testify recently and we did have a meeting with doctors on the Part A and B reimbursement recently and I keep in close touch with physicians. That is, when we set these hearings up, and we send out invitations and some people can make it and some can't, so you have provided a very good service here this morning. I think your point that, you know, sometimes it's hard to get doctors to work in the VA or here or there, and also your service with the Medical School is very important. Our State is fortunate to have that facility.

Does anybody here want to make a response to any of Dr. Shreves' remarks. I think it was a good addition to the hearing. I don't know if there's a response needed. Does anybody have a comment they want to make in direct relationship to that? Let's see. Let's have another—do we have a question? Yes.

UNDESIGNATED SPEAKER. I was impressed when I heard the Pepper Report on television. In fact, I was fascinated on the nurse

and long-term health care. My husband manages two elderly accounts and keeps the people going as a legal guardian, and we're really concerned about it and my question is: How is the financing—you know, I listen to them when they brought out all the recommendations, but the financing is not one of their studies, and they said that they thought they would let some other areas do the financing, work out the financing. I wondered if there has been any progress made in this area.

Senator PRESSLER. Frequently, people make a series of recommendations and it's up to Congress to come up with the financing and what happens, whether it's any area of the Federal Govenrment—we're now going through what we call the authorization process. We get all these wonderful bills passed, but we get into the actual appropriation process in September. Gramm-Rudman-Hollings comes in. The huge Federal deficit we have becomes a factor. All the elements of our Federal programs come into play, and the toughest thing is where do you come up with the money? So the Pepper Commission Report, which we have copies of available here, is a wonderful report, but it's up to all of us to try to find out how to finance it and that is a real problem. Some feel there will be a significant peace dividend in the early 1990's, that we're going to reduce some of our spending on the European basis. Some feel that that there may be other sources of revenue, other sources of efficiency. The Pepper Commission, however, was careful to keep its recommendations somewhat limited, and they felt that in the early 1990's growth in the economy plus somewhat of a peace dividend could pay for most of their projects, but that was the main question asked them at their press conference about financing of it. I should say that I have one of my other senior citizen interns here, Fern Stringham, who was just in Washington. Fern, where are you here? There you are. Thank you very much for being here.

Mrs. STRINGHAM. May I make a comment?

Senator PRESSLER. Yes, you may. Why don't you take the microphone?

STATEMENT OF FERN STRINGHAM

Mrs. STRINGHAM. Thank you. I only qualify as a daughter who wrote $36,000 worth of checks on my mother's account in her last 2 years. Those people that think that Medicare—if you're on Medicare, your problems are taken care of, just take a doctor's visit. Usually for us, its $22. For her, the cost was $21.42. Medicare said they only approved $13.20 and then they pay 80 percent of that, so when you think my mother went to see the doctor and Medicare paid for for it, she paid $10.86 herself of the $21.46, and I just want to bring that to your attention that Medicare in Washington thinks we're a rural area, and the Sioux Falls doctors think they're in a medical center, and the elderly person is put in the middle of this confusion.

Senator PRESSLER. I might add that John Larson is here. He's a member of my Health Care Advisory Committee. I have a Health Care Advisory. Where's John? Right there. Glad that you're here. Anyway go ahead.

STATEMENT OF GARY BRINK

Mr. BRINK. Good morning. I'm Gary Brink. I'm the administrator of Covington Heights, which is a Medicare facility, and I would like to say a little bit about when a person comes into the facility, Medicare pays all their costs for 20 days, if they qualify, and then for days 21 through 100, the person has to pay $74 a day. That's not a bargain. Additionally, I have 24 Medicare-certified beds. Any time Medicare owes me less than $200,000, I jump for joy. It's not a good—that's the reason there are only 16 Medicare-certified facilities in the State. Thank you.

Mr. ELLENBECKER. I would agree with you. This has been a major problem in that Medicare really has not joined the ball game to participate in the long-term care system. Hopefully the Pepper Commission and the Slot Committee will really take a look at this as a viable way of assisting the long-term care system.

Mrs. NICKELSON. I think, personally, one of the problems we face is that our Congressmen are out there for us, but we have to realize that we're dealing with a lot of populous States compared to ours and a lot of the decisions made just on the vote alone doesn't—they don't understand rural health care as it really is.

The States west of the Mississippi, all of them face a real problem, and until we can help our Congressmen by getting the word out to those people—I mean write to other Congressmen even though they aren't our own and let them know the real cares that we have here for rural health care. When you're dealing with someone from New York City, they don't understand rural health care like we're facing here. They just don't, and so that's where we have to help in writing letters to more than just our own Congressmen but to other people, and even to President Bush and say, "Look, this is the way it is and we have to do something." I agree—I know for a fact being over there that Sweden has a very excellent socialized medicine plan, especially for their senior citizens. It's wonderful and it doesn't cost them individually that much more every year. It comes out in their taxes. They have a higher tax rate than we do. They certainly are able to provide all the medical care that they need, and I agree I think that's something we should really look at, especially in care for the elderly because our population is getting older and we're living longer. That's just a fact of life, and when the baby-boomers get up in the 65-and-older bracket, you know, they're going to face a lot of the problems that we have facing us. Thank you.

STATEMENT OF WILBUR FOSS

Mr. Foss. I'm Wilbur Foss from Yankton and in 1985, I was president of the Senior Intern, and I kind of agree with the doctor here because I was shocked when I found out in Washington in 1985, and I suppose it still holds true today, that senior citizens pay a higher percentage of their income for health care out of their own pocket than before we had Medicare.

I'd also like to comment on that lady's talk from Yankton. I don't know her, but I've been a resident of Yankton for 25 years, and the State of South Dakota has treated those workers at the Human Service Center in a very shabby manner. We've treated

them like second-class citizens and very nearly like slaves, and now they're being criticized because they want to unionize and I'm not in favor of that either, but they tried everything else and it hasn't worked.

After I was in Washington in 1985, I determined I was going to find out more about the problems of aging. I got my eyes full, and I'd just like to make a few remarks to give you something to think about.

I live in Yankton, town of 12,000, a very progressive town, very progressive. We have the best schools. We pay our teachers better than anybody in the State, practically, at least in towns our size. We have every kind of sports program. We have a good 4-year college. We have a good hospital, and we'd like to give the same kind of services to our old people, but the State of South Dakota won't let us do it. We've had two private people that wanted to build—they didn't ask for any grant; they didn't ask for any loans; they just wanted to serve the needy; and they weren't allowed to.

Here's something else that the State of South Dakota let happen in Yankton. They let a nonprofit group buy out two homes in Yankton—put them out of business, and they paid a high price for those permissions to operate. They paid a blue-sky price to get them, and then they turned down private people that want to pay. I just don't think that's right, so I made my own little survey. I drove from Tripp to Elk Point. I found—I inspected all those—not inspected—I visited all the managers, and they were all very receptive to any questions I asked. Maybe the second time around they wouldn't be the same, but here's what I found out: From Tripp, Meno, Scottland, Freeman, Yankton, Wakonda, Irene, Viborg, Beresford, and Centerville, there were 9 empty beds, and the State of South Dakota doesn't think that they need any more rooms in Yankton. Can you imagine a legislature putting on a 3-year moratorium when the people are getting older and we have inflation? It's going to cost more money to build in 3 years from now, and if you really want to find out what makes—how the system is working, I'm not going to tell you about it, but you write to Pierre and you find out some of the people in political power that have gotten certificates of need for their own towns after being turned down in the previous administration and told that there was no need in their communities. This was by the same Secretary of Health, so think about that. Now, I'm not against the nonprofit groups, not against any religious groups. I'm critical of the State of South Dakota and it happens to be my political party that's in power, and I think one of the nonprofit groups kind of hides behind my church.

If you want some other interesting figures, get the assessed valuations of these institutions that are not taxed, and if you want some more interesting facts, find out about the rates. For the life of me, I can't understand why people that don't pay taxes can't offer better rates. I was in a hardware business 17 years. If I wouldn't have had taxes I could have sold everything cheaper. I was in the banking business for 25 years. If we wouldn't had to pay taxes we could have dropped the interest way down. These are some of the things I want you to think about.

I have a 102-year-old aunt in a nursing home in Freeman, who started out homesteading in Montana years ago. Her farm is all gone. It's all spent. She worked hard. She would have liked to have left something to her children. Now, there's nothing. If she had not been a real honest person, she could have willed that farm 5, 6 years ago to her children and the taxpayers, but she was too proud to do that.

Now, I would just like to leave one more thought with you. I asked a lady that runs a nursing home, "What incentive is there for you to be efficient?" She snapped right back at me, "Absolutely none, if we're more efficient they will lower our price per day." So I guess turn the heat up and open the windows and let the chips fall where they may. I'm kind of bitter about this because we would like to get people in Yankton, that have lived there—they help pay for my education. They helped pay taxes for the things that my daughter enjoyed, and we kind of treat them like second-class citizens. We send many of them over to little towns where they don't have doctors. The homes are good and we get to lot of homes. I have a group of musicians. We visit about 60 homes and I think the homes in South Dakota are very good, but I think a person ought to have a choice and I think in a town like ours we ought to have a choice of about four places any way to go and I'll—just one more statement. When I came to Yankton 25 years ago, we had three financial institutions and four nursing homes. Now, at the end of the year, we will have seven financial institutions and two nursing homes.

Senator PRESSLER. Wilbur Foss, thank you. He's one of the great thinkers in our State. I was proud to have him as my senior citizen intern. He's also a great horseman having ridden a horse all the way up the Missouri River. He's also a great musician. His group of fiddlers and musicians provide entertainment to hundreds of South Dakotans. He's one of the great men of our State, and I thank you for your statement and there may be—I'm sorry I didn't introduce you earlier, Wilbur. There may be other people here who should be introduced, but we should have introduced you. I'm glad you made your statement. Does anybody here want to make a response you want to say?

Mr. ELLENBECKER. Thank you, Wilbur. We're very familiar, as you well know, with the situation on the moratorium. I think its something, as I mentioned in my formal remarks, that the State had to do to stop things in time, by putting in place the moratorium. I think that most States around us now have similar kinds of moratoriums to give the system that we presently have, which is institutionally based, time to develop alternatives. I think every panelist here pretty much mentioned that we need to develop a more extensive home care system, and that we've got a review going on in our second year of that moratorium. The Governor has appointed a task force to take a look at what to do now that we're approaching the end of the moratorium and to give him constructive criticism on his long-term care alternatives plan. We will hold hearings on this later this summer. The Governor's task force has been appointed to review the progress of that plan and make recommendations that can be enacted by the legislature and the Governor in the next year or two. So it's something we're very familiar

with, as you well know, and we really believe our present plan is working. We have been able to address those situations in those communities to see that, in fact, alternatives provided were all appropriate, and we think the plan is working.

Senator PRESSLER. Anybody else want to comment on that particular area? Dr. Battin, would you like to take the microphone. You want to make a comment? Anyone else who has a comment? We're just about out of time here, but this is—we're getting some very good testimony.

STATEMENT OF DR. AUSTIN BATTIN

Dr. BATTIN. I'm Dr. Austin Battin from Yankton, and I'm having a very hard time following that angry young man that just spoke. He's a patient of mine. I have a lot of respect for him.

I have to apologize to Dr. Shreves because I sat here through this whole presentation—the people who make the regulations, see that all the regulations on health care in the Federal and the State level have no representation here. I'm an optometrist. I listened to Dr. Schmidt, who's a chiropractor. I listened to a licensed practical nurse. All of these people are also regulated by those people who are not represented here. Our scope of practice is limited by the legislative process as Dr. Schmidt is, and we have people who are qualified and certified and we cannot practice because we have to pass legislation in order to improve our scope of practice and use our expertise. The people who make the regulations for Medicare and Medicaid, and all of these things, are the people who oppose any kind of change in a health care facility. Optometry may be the best kept secret in health care in the State of South Dakota. We're capable of providing services. We have people in place where it's needed in the rural areas, and like Dr. Schmidt said, we're subject to the mandates of the State legislation, and we cannot function freely even though we're capable.

Bonnie, your organization, as a rule, in your health care program which says I may not provide service to your people unless they are referred to me by a physician. Now, that's duplication. You might look into that. We have facilities that we're not utilizing, and it's being regulated by people who are pretty fat cats. They're perfectly happy. The only reason Dr. Shreves is here is because he's retired. Right? I have a great deal of regard for him, but where are all those busy physicians? They aren't here. They aren't here talking to us, and I think they're a little afraid of the heat that they deserve. They are the reason we do not have a national health plan. I think something ought to be looked into in that regard.

We got a lot of people here who are interested in not gaining anything except some dignity and some care for their waning years, and we have the facilities. Let's use them.

I thank you for allowing me to speak. I gave a written statement, which it's not necessary to read it, but I want to include it in the record.

[The prepared statement of Dr. Battin follows:]

Yankton Vision Clinic
Dr. P. Steven Anderson
Dr. A. W. Battin
1014 West Eighth Street
Yankton, SD 57078
(605) 665-7762

May 25, 1990

Prince of Peace Retirement Center
4500 Prince of Peace Road
Sioux Falls, SD 57103

Attn: Senator Larry Pressler Hearing

"Rural Health Care for Elderly."

Comprehensive health care facilities in South Dakota are located in seven or eight centers throughout the state. Almost every rural community of one thousand people has a care center for elderly care with limited support from professional health care physicians.

Optometry provides a source of care distributed geographically that makes them accessible where the need is. It is the optometrists who provide the majority of primary eye health and vision care in South Dakota. The profession is regulated by legislative edict and this is subject to pressure from the medical industry in the area of therapeutic care. We are not permitted to manage glaucoma and are allowed limited use of steroids and no oral agents. These are state matters and may be resolved further on.

On the federal level we are Medicare providers but do not presently receive equal pay for equal services provided by optometrists and medical physicians. We would respectfully request your help in seeing that this situation is corrected.

Another area of concern is in the area of post operative care of our patients who we refer for surgery on cataracts. Ophthamology has brought strong opposition to bear to retain optometric patients under their care for two to three months after surgery. Certified optometrists are qualified and capable of managing and monitoring our patients recovery.

In many cases, optometry is qualified and willing to manage eye health problems where the patientis and can do it in a way to relieve the patient of the need to travel long distances when they don't have transportation available.

Eye health care for the elderly should be provided efficiently at the least cost in the most accessible location to be effective. We feel optometry can provide this service and should be utilized to the fullest extent possible.

Respectfully submitted,

Austin W. Battin/OD

One of AOA America's Doctors of Optometry

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Senator PRESSLER. Thank you very much. We have time for one more question here or comment. Go ahead and take the microphone. I don't want to turn anybody off. If other people want to make a brief question or comment, just line up behind her, and we'll hear from you. We're just about out of time where we have to be out of this room. So go right ahead.

STATEMENT OF SISTER ADRIENNE KAUFMANN

ADRIENNE KAUFMANN. Thank you, Senator Pressler. I'm Sister Adrienne Kaufmann from Mother of God Monastery in Watertown, and I just want to open up one of the broader perspectives I think we haven't talked about, except Bonnie Brown, when she said there is a lot of money going to S and L's. I think that one of the reasons we're here with a very serious health care crisis is because we have spent about 45 years now with a national priority of stopping Communism spread around the world, and that has taken billions and billions and billions of dollars away from building the infrastructure. We're paying a price for that now in the sense that we have let our infrastructure take second place, and it truly has. We also now have a military-industrial complex that maybe isn't needed because that goal is stopping the spread of Communism is well on the road to achievement, but that bureaucracy is now in place, and I would like to urge you, Senator Pressler, to begin to address the need to shift our national priorities back toward the infrastructure so that we have a people with a quality of life that really is worth defending. Thank you.

Senator PRESSLER. Thank you very much.

STATEMENT OF KAY LYNN JOHNSON

Mrs. JOHNSON. I'm Kay Lynn Johnson and I'm administrator at Good Samaritan Lutheran Manor and I want to talk again on behalf of staff. I am concerned about the level of care that we are receiving at the nursing home. The care has increased greatly. We have very few people who can do much of anything by themselves. They require 24-hour care, and along with that our staffing requirements, in terms of legislation, have not really increased that much, and yet we need more staff there and when we run short that means our worker's comp goes up. I think that we can see an increase in worker's comp in direct relationship to our staffing situation, and I am concerned about the rising costs, both in wages and in worker's comp.

STATEMENT OF AMELDA McGEOUGH, HEART ATTACK VICTIM'S WIFE

Mrs. MCGEOUGH. I'm Amelda McGeough. After hearing doctors and assistants and so on, I'm just a farmer's wife and we're novices to the whole Medicare program and did we learn a lot.

I'm going to disagree with the charges about the doctors. Our basic input about the Medicare—what it was came from my husband's brothers and sisters who live in more urban States. Their doctors charge a lot more than they do here, and Medicare approved a lot more of those charges, and this is one of the things that I have not been able to find an answer for how we—I believe I

have my facts straight, we are paying the same amount out of our Social Security for Medicare than people in California and Arizona do. Is that correct?

Senator PRESSLER. Yes.

Mrs. MCGEOUGH. Okay. But our coverage does not compare with what it does in more urban States, and this is what I—that has—I even—I don't even talk in proverbs. That's rattled my cage, and it has bothered me because we have been left—I suppose we should have gone to meetings. We should have talked to people about it, but most of our friends are not on Medicare. We're just new to the whole business, and so we had no idea that this was going to happen. We kept hearing, in fact, when my husband was down here in the hospital when he had by-pass surgery, his brother, John, from New Jersey, said, "Aren't you glad Morris is on Medicare." At that time, I said, Yes. Two weeks later I thought, I think we'd have been better off with our own private insurance. I will let somebody else with more authority—I just can talk that's all.

[The prepared statement of Mrs. McGeough follows:]

TESTIMONY SUBMITTED BY IMELDA MCGEOUGH

Willow Lake, S.D. 57278
May 24, 1990

Gail Wilensky, Administrator
Health Care Financing Administration
Dept. of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201

Mrs. Wilensky:

I read your interview in the AARP Bulletin with an interest heightened by our own experience. It is eight months since my husband, Morris, had a heart attack, and we are still involved with some of the first Medicare claims. Being on Medicare is like having a demanding houseguest. It takes up our free time, strains our budget, dominates our conversation, and occupies our space--especially the top of the desk and the kitchen table. Houseguests eventually leave. I'm afraid at our age, Medicare has taken up residency.

Our negative feelings about Medicare are augmented by a number of circumstances. The most informative in-put we had about Medicare came from older siblings who do not live in South Dakota. For them, Medicare and a simple supplemental insurance gave adequate coverage. Because Medicare is federally funded, we assumed that coverage was the same nationwide. Wrong!!!!

When Morris reached 65, he applied for Medicare, got the AARP-Prudential supplement insurance, and we went on with our busy lives--and as we learned a false sense of security. Our naivete about Medicare left us totally unprepared for what has happened since Morris had a heart attack last September. (Within six weeks, Morris was hospitalized twice in the ICU at Prairie Lakes Hospital in Watertown, S.D.; transferred to Coronary Care in McKennan Hospital in Sioux Falls, S.D.-once by air and once by ground ambulance; had an Angioplasty and By-Pass Surgery.)

When we got the first check from Medicare, we learned how inadequate our coverage was. At first we blamed ourselves. "We should have attended some meetings about Medicare. "We should have checked the AARP-Pru supplement--insteading of trusting their brochures." We are long past the 'mea culpa' stage. And now we are just plain angry!! How could a medical insurance program for older people that should be simple and reassuring be so misleading--and complicated--and frustrating--and time consuming--and expensive--and I haven't run out of descriptive words, but that should give you an idea of how we feel about Medicare.

The inadequate coverage has strained our finances, and has made us question the credibility of the whole Medicare system. How can a federally funded program vary so much from one area to another when we all pay the same amount to Medicare? In South Dakota, Blue Cross-Blue Shield is the Intermediary and Carrier for Medicare. (It is also the company that Morris now pays$67.50 a month for their Medi-Gap Plus policy.) Blue Cross-Blue Shield secured the Medicare contract because their bid was the lowest. I am not certain if the lov approval rates for doctor's and surgeon's charges is a reflection of that low bid, or inadequate government funding, or a combination of both. Suffice to say, the rates of approval by Medicare are much lower in this area than in more urban states.

Using the Explanation of Medicare Benefits, I calculated the rates of approval for the doctors, surgeons, and the Ambulance Services.

Dr. Shives, Family Practice----------59%
Dr. Hurley, Cardiologist----------60%
Dr. Reynolds, Stand-By Surgeon----------0%
Dr. Owens, Surgeon----------75%
Air Ambulance----------19%
Ground Ambulance----------76%

In South Dakota, doctors charge less and Medicare's rate of approval is much lower. Because of that, few doctor's accept assignment, and I don't blame them. The sad part of the over-all situation is the fact that our rural population is an aging one. Approximately one-third of the patients treated at Brown Clinic are on Medicare. (The clinic has hired more office staff to handle the Medicare paper work.) We need young dedicated, capable doctors, and they are leaving South Dakota. Medicare is partially responsible for that exodus.

Mrs. Wilensky, I could write a book about Medicare. I was told that Medicare never pays for a Stand-By Surgeon during an Angioplasty --and that was the rule. If that regulation dates back to Medicare's infancy, it needs to be updated. Angioplasty and a lot of other procedures made possible by the advances in medical technology didn't exist at that time. In rural areas, the nearest hospitals fully equipped for Coronary Care are over 100 miles away. But Medicare refuses to pay for Air Ambulance Service.

Two of the most frustrating experiences with Medicare date back to September 21, 1989. When Morris had the heart attack, his condition was so unstable that Dr. Shives remained at the hospital all night. He monitored Morris's condition and supervised the medication until the para-medics came with the Air Ambulance. Medicare refused to pay Dr. Shives $87.22 because frequent visits are not covered. Brown Clinic requested a review, and the claim was reviewed and re-opened. We received copies of the letters sent to the clinic. The first, dated March 12, 1990, states that the claim was reviewed and further payment refused. The second, dated March 13, says the claim was re-opened, and further payment would be made in 2 or 3 weeks. That is over two months ago, and we have not received anything from Medicare.

That is how Medicare treats a dedicated doctor! And it is also an example of how money is spent on unnecessary paper work. For this one claim, there were two separate reviews done by salaried people who generated the paper work done by the salaried office staff. My practical mind tells me that Medicare could have paid Dr. Shives--and saved money.

Another example of repetitive paper work--we have requested that Medicare re-open the Air Ambulance Claim. The following information was needed:

A personal letter requesting that the claim be re-opened
The Explanation of Medicare Benefits
A letter from Dr. Shives telling why air transfer was needed

We had never received that EOMB, so I called the Medicare Office and asked them to send it. I had it copied so I could return it to that same office. Dr. Shives had to write another letter even though the information from him was already on file. The only information Medicare needed to re-open the claim was our personal request.

It would be interesting to know how much of each dollar funded for Medicare is used for medical care and how much is spent for office staff salaries and paper work. To make things even more complicated, in South Dakota two different offices process Medicare claims. If you have a question about a claim for a doctor, you call the office in Fargo, N.D.; for a hospital claim, you call DesMoines, Iowa. If you make the mistake of asking for information that overlaps, you are quickly and rudely told that you have the wrong office.

Mrs. Wilensky, if our experiences with Medicare are typical, the whole system needs to be revised. Your job is a formidable one--and I hope you reach your goal. As the wife of a Medicare Beneficiary who is 'stuck' with the paper work, I wish you success.

Sincerely,

Imelda McGeough

Copies to:
Senator Larry Pressler
Senator Tom Daschle
Representative Tim Johnson

Senator PRESSLER. Thank you. We have two more speakers.

STATEMENT OF JOHN LOWK, STUDENT, SOUTH DAKOTA STATE UNIVERSITY

Mr. LOWK. Good morning, Senator. I'm John Lowk. I'm a student of politics of South Dakota State University, and I'm sure, as Senator Pressler is well aware, he sits among the most influential, wealthy, and powerful interest groups in the Nation, and my question for him is, it might be kind of a tricky one, does he support the policy stand of the national health insurance policy even though—even in light of the shortcomings and rationing of care that takes place in Great Britain and Canada, which has that type of a system?

Senator PRESSLER. Well, I thank you very much, and let me say that I support allocating more of our priorities into the medical area. I've lived in England as a student, and also when I was in the Army, I lived in a number of countries. Let me say that some of these areas, be they Canada or England, are not a mecca because health care services are very rationed there. A lot of people don't realize that there's a long waiting period, after you're age 60 you can't get certain procedures, and so forth. Indeed, in terms of delivery of health care services, we have the best system in the world without a rationing of those services. So it depends on what you mean by a national health care policy, but certainly I hope in the 1990's we're able to allocate more of our resources into health care for our own people here at home, take care of them. I also hope very much that we can lower the amount of paper work. We have these complicated situations. I'll be glad to go into that in more detail afterwards, but that's basically a summary of my position, but I would say that I don't think we would be willing to accept the rationing of health care services that occur in the Canadian and the English system. In any event, go ahead.

UNIDENTIFIED SPEAKER. I don't want to seem callous, but I think there are some decisions to be made at the point that it's evident that a person is going to be dying, not to keep prolonging and prolonging. It now costs about $110,000 per person at that point. We had three of our four parents die in a 7-month period, and we went through great emotional stress in trying to make decisions of what care to give and what care not to give. Two were in nursing homes; one in the hospital at the end, and at some point we each have to let go of our own lives; we each have to let go of lives of our loved ones; and if we can prepare ourselves emotionally and spiritually and socially and in other ways emotionally, to do this, we will, in a sense, cut down on the cost of dying and allow that to be a more natural process which originally it was. I also don't want to seem simplistic, but I really want to echo what has been said here about changing national priorities. There will be some heavy adjustments if we decrease defense spending too fast and dislocation, but there is so much greater need in some of the social areas and in health and in education, and environmental things, that jobs will open up in those areas and training can be done in those areas instead of the heavy defense. It seems to me that when we were increasing defense costs at the high percentage rate, 6 to 8 percent in some

years in the 1980's, and then we say, "Now we can start decreasing them by 2 percent a year." It just seems very illogical to me. I think we can be faster at it, and I would like this change to help educational and environmental issues, things that touch people's lives on a daily basis. Thank you.

Senator PRESSLER. We have got to give this room up here.

STATEMENT OF CHARLOTTE ZUKE

Mrs. ZUKE. Can I ask one short question? How can I find out that I could be let to die in my own home and that nobody can keep me artificially alive when it's my time to go?

Senator PRESSLER. Lil, could you talk with her afterwards? Yes, why don't the two of you get together afterwards. Yes?

STATEMENT OF DR. SCOTT ATCHISON

Dr. ATCHISON. Senator, I'm Scott Atchison. I'm a physician here in Sioux Falls. I'm not retired. I'm in active practice. I don't think I'm a fat cat. I'm a long way from retiring. I'm here to appeal to you, to Senator Dachle, Congressman Johnson to work for our senior citizens who I'm privileged to serve. I want to maintain access for those patients to quality health care in South Dakota, and I'm willing to work toward those goals.

Senator PRESSLER. Thank you very much and we very much appreciate your presence and we would like to have written statements from any of you. I'm going to have to turn off the formal part of this meeting. You may say what happens now? Now, we give a summary of what was said here, to each Senator on the Senate Aging Committee. I want to thank you all for being here. Thank you for your testimony. Thank you the people on the panel, and thank you all for your patience. Thank you.

APPENDIX

Item 1

Church of Saint Anthony

P.O. Box 969 • 501 Jennings Avenue

Hot Springs, South Dakota 57747 • (605) 745-3393

May 24, 1990

Senator Larry Pressler
Committee on Aging
P.O.Box 1372
Sioux Falls, SD 57101

Dear Mr. Pressler,

I am writing on behalf of Mary C. Kelly and because of my own personal concern for the plight of the elderly within our state. I would hope that our concern could be entered as part of the testimony on the hearings for concerns for the elderly.

First I am deeply concerned at the rising costs in health care for the elderly. Mary Kelly was a teacher in South Dakota most of her life. Now at 87 she is in need of nursing home care. She entered the nursing home in October of 1989. Since that time the rates have been increased at the Castle Manor here in Hot Springs, and now I understand that they are to be increased again. While the costs keep going up the quality of the services provided continues to decline. What savings she has been able to acquire through her years of work are gradually being eaten up with the rapid rise in medical and nursing home fees.

Because of her age she is unable to obtain any supplemental insurance or nursing home insurance. And at the moment, even if that were possible the cost would be prohibitive.

In a society which has been built upon the labors of our elderly I find it hard to understand that now when they are vulnerable to the effects of aging both their health care and quality of life is placed in jeopardy due to exorbitant medical and nursing home costs.

I earnestly hope that through the efforts of the Committee on Aging Medicare and other Federal Agencies would see the need to assist the elderly of our country to maintain a quality of life and care. If the rules covering Medicare were less restrictive in the area of what is covered and its duration -- for example, our elderly are only entitled to 21 days of hospitalization a year. What are they to do if their illnesses last longer than that time? If Medicare would also help with nursing home costs this would greatly ease the heavy burden that has been placed upon our elderly.

I would like to thank you, and the Committee, for taking the time to consider the needs and problems facing the elderly. It is my hope, and prayer that something can be expediently done to assist them and improve the quality of their life and care.

Asking God to bless you in your endeavors, I remain,

Sincerely Yours in Christ,

Fr. Peter B. Wilke

Item 2

614 Sheridan Lake Rd #208
Rapid City, SD 57702
May 22, 1990

Dear Senator Pressler:

I would like to take this opportunity to file this information with your Panel Hearing on testimony on Rural health Care issues affecting elderly people on Medicare and Supplemental Insurance.

Medicare on June 1, 1989, as you know, placed a maximum of $355.00 allowed for oxygen and when Medicare puts a maximum payment on, Blue Cross Medigap Plus will only pay the 20% of $355.00. Why just oxygen was the maximum put on?

Because I have a heart condition without oxygen, I have cyanosis and it is a matter of life and death. I am on 5 liters per minute continuously 24 hrs per day, liquid oxygen as the machines will not work with that many liters, I burn the motors. The cost of liquid oxygen and base and portable is $2000.00 per month. You see for me to live I must make monthly payments for the bill. Blue Cross when I signed up for Medigap Plus knew I was on oxygen and amount and never mentioned it and then Medicare were to place a maximum on oxygen my Medigap Plus would not pay only the 20%. I believe this is very deceiving on the part of Blue Cross. I am paying $204.75 every three months for Medigap Plus.

I hope this will be of some help at your meeting. I do appreciate all you have tried to help me.

Thanking you in advance.

Respectfully,
Maxine E. Stevens
614 Sheridan Lake Rd #208
Rapid City, SD 57702

Item 3

Senator Larry Pressler

This hearing on health care put forth imperative issues. I appreciate the efforts of your Committee in holding this hearing and hope the findings will be publicized. It is gratifying that this is a matter that has support of both parties -- it transcends political lines.

We wish to support your efforts and encourage you in the up-coming election. You have served us well and your years of experience are valuable to us. Seniority is a force in Congress!

We regret some of the false claims of your opponent. Several of the endorsements he claims cannot be true as organizations such as Parent Teachers and AARP are non-political, non-partisan.

Be assured that the so call organization of Senior Citizens is not a major organization in our state. National televised Association of Retired Americans is not AARP.

Wishing you continued beneficial service to our elderly.

Respectfully,
Marjorie Songstad
209 W. Norway
Mitchell, SD
57301

Item 4

DR. DONN FAHRENDORF
Chiropractic Physician
1705 South Cliff Avenue
Sioux Falls, South Dakota 57105

Telephone 338-6411

May 23, 1990

Senator Larry Pressler
Senate Aging Committee Hearing
4001 West 41st Street
P. O. Box 1372
Sioux Falls, SD 57116

Re: Rural Health Care For The Elderly

Dear Senator Pressler,

This testimony is to provide you and your staff with a brief overview as to the needs of expanded Medicare services for the elderly. This testimony will deal only with the relationship of Chiropractic Health Care and Medicare services.

At the present time the general rule for chiropractic services, covered by Medicare, is limited to twelve visits per year with manipulation of the spinal vetebral subluxation which must be verified by x-rays to be deemed medically necessary. The cost of the x-rays is the responsibility of the patient, and any additional x-rays or updated x-rays to justify continuation of treatments, must also be paid by the patient. This regulation is, in effect, a required admission fee if the patient hopes to receive any reimbursement for chiropractic services.

All of the non-covered costs must then be submitted for reimbursement through supplemental insurance policies for those patients who can afford to purchase them. Patients who do not have supplemental coverage are responsible for their deductible, the difference between the doctor's MAAC and the Medicare payment (for the 12 treatments) and all other additional x-rays, treatments, therapies, and orthopedic supports.

Unfortunately, many of the elderly who are unable to pay for any or part of the full treatment from a Chiropractor, either do not receive it, or seek care from the M.D., hospital, or physical therapists, whose services are authorized for full reimbursement from Medicare. Although in many instances, a D.C. may provide the same services at a lower cost, (and keep the patient out of the hospital), the beneficiary is nonetheless forced to seek out more expensive care than can be more fully reimbursed under Medicare.

Reimbursing a patient for services rendered by one qualified class of health care practitioner and not for those rendered by an equally qualified class of practitioner interferes with a patient's freedom of choice--again, it is an economic disincentive which stifles health-care competition and leads to increased costs.

Medical reimbursement for chiropractic services constitutes less than 0.5% of the Medicare budget. The balance of chiropractic services paid by those over 65 years of age and older was financed either by private Medigap insurance or patient out-of-pocket resources.

Whenever the Chiropractic Profession requests consideration or expanded reimbursement for services to our patients, the bureaucracy is quick to justify their limitations as an attempt to control costs. I do not feel that a minimal increase in benefits of the existing 0.5% is going to have a strong economic impact on costs. Common sense would dictate that Medicare should review the possible wasted dollars of the other 99.5%. A small fraction of these dollars could be more economically spent treating the patient with chiropractic services.

I greatly appreciate you offering my profession and me an opportunity to express this ongoing concern. South Dakota has a high number of elderly people, especially in the rural community, who should not be denied the freedom to choose their own course of health care. Neither the Federal Government nor the medical establishment should deny or limit this basic right.

Sincerely,

Donn J. Fahrendorf, D.C.

DJf/fo

Item 5

J.A. Kleinsasser
2815 S. Main
Sioux Falls, South Dakota 57105

1982

In our walk through life we encounter all manner of experiences to which we must adjust. Often we adjust negatively to our hurt. With special grace we can react positively and learn much.

I am not a counsellor, psychologist nor pastor, but because of my recent experience in taking care of my wife, Susie, an Alzheimer's patient, I have arrived at conclusions which have been helpful and I list them here. Perhaps you reel yourself in my place at some point, and may be encouraged.

I find myself "trapped". I am in this situation through no known fault of mine or Susie's. My only other option would be to place her in a nursing home--which I find impossible to do at this time. For some there may be no other option.

a. I must not keep asking "why" but rather concentrate on how better to cope.

b. I must avoid self-pity, nor can I encourage it from others.

c. I must avoid a guilt complex although I know that I often do not function well.

d. I must not become deeply emotional each time a crisis occurs. Things do happen accidentally and unexpectedly.

e. I must try to take care of myself as best I can, through exercise, proper food (even though I am the cook) and occasional release from my "trap."

f. I must learn to accept from others what they sincerely offer, even though I prefer to be self-reliant.

g. I want to encourage visitors or company even though Susie no longer is able to show or enjoy any measure of hospitality.

h. I must learn to live one day (sometimes one hour) at a time even though I have no idea how long Susie (or I) will be here.

i. I must not lose my sense of humor.

j. Should the time come when I can no longer take care of her myself, I must either get help here or place her where adequate facilities are available. (She died Dec. 2, 1983)

I have not lived up to the above nor must I expect to do so. My biggest problem is that of patience, but even that can grow.
Romans 5:3

WHAT TO SAY

A volunteer clipped this Ann Landers column to include in our newsletter. It reads: "Dear Friends and Neighbors: You are all aware that my husband is terminally ill. We do not ask that you run errands or bring food or send flowers. What we do find surprising is that you haven't phoned to see how we are getting along, much less dropped by for a brief visit.

Perhaps you don't know what to say because you find dying hard to deal with. That's OK. I can understand that, so here's a little advice: Be natural. Treat us the way you would if my husband wasn't dying. Tell us what you've been doing. We'd love to hear about your trip or the kids or your in-laws. Tell a few jokes, or let's talk politics. Believe me, anything you care to talk about will be wonderful to a couple of people who haven't seen a visitor in months.

Just give us a call and let us know when you'll be over. I'11 put the coffee pot on, and I might even bake some cookies." Signed, No City, Just New York.

Item 6

230 East 30th Street
Sioux Falls, SD 57105
28 May, 1990

Honorable Larry Pressler,
United States Senate,
Senate Office Building
Washington, DC 20013

Dear Senator Pressler:

I appreciate the opportunity to attend your special hearing on Aging and wish to submit the enclosed information for your information and remarks.

It is my understanding that I, along with all other Senior Citizens, pay the same amount to the Social Security System for coverage under Medicare. However, I further understand that the amount of payment approved and paid by Medicare is much less in this geographical area than would be paid for the same or like service in other areas.

I would appreciate an explanation on this matter and would respectfully request a report on the difference.

I am enclosing a Case History on my recent hospitalization along with copies of doctor's bills and Medicare Explanation of Benefits.

Respectfully submitted.

Sincerely:

Perry L. Pollard

PERRY L. POLLARD

Encl:

CASE HISTORY PERRY L. POLLARD SSN 508-07-3997

I was admitted to Sioux Valley Hospital in Sioux Falls, SD on Sunday January 14, 1990 and was treated for a Heart Attack by Lloyd E. Solberg, M.D.

I was discharged from the hospital on Friday, January 19, 1990. Although there were several different charges made by the Hospital, Radiologists, X-Rays, Laboratories etc, I will limit this example to only those charges made by Dr. Solberg and North Central Heart Institute. (Acct. No. 310208)

Please note that on the enclosed itemized invoices from North Central Heart Institute, I was billed a total of $5,154.10. You will note that Medicare approved and actually paid only $1,649.12 or 32% of this amount.

Special attention is called to the one item on January 14th for $1,200.29 listed as "Combined RHC,LHC,COR" which Medicare rejected as "inpatient visits that were or should have been included in the major surgical fee". I intend to ask Doctor Solberg for an explanation of these charges so I can ask Medicare and my supplemental insurance company for a review of this claim.

Thank you for your attention to this matter, and hope it will be helpful in youe survey of Medicare coverage.

Respectfully submitted.

Sincerely:

Perry L. Pollard

PERRY L. POLLARD

ENCL: North Central Heart Institute Invoices
Medicare Explanation of Benefits on
Claim Control Nos: 0290-046-541990 & 0290-046-542000

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

Page 1 OF 2

March 02, 1990

PERRY L POLLARD
230 EAST 30TH ST
SIOUX FALLS SD 57105-3923

For more information call or write
MEDICARE PART B
4510 13TH AVENUE S.W.
FARGO, NORTH DAKOTA 58121-0001
PHONE AREA CODE 701-282-0691
CALL TOLL FREE 1-800-437-4762

Participating doctors and suppliers always accept assignment of Medicare claims. See back of this notice for an explanation of assignment. Write or call us for the name of a participating doctor or supplier or for a free list of participating doctors and suppliers.

Your doctor or supplier did not accept assignment of your claim totaling $ 308.87. (See Item 4 on back)

		BILLED	MEDICARE APPROVED
LE SOLBERG MD INPATIENT VISITS-1 JAN 16-JAN 16,1990		$ 48.01	$ 42.90
Amount approved limited by Item 5C on back.			
LE SOLBERG MD INPATIENT VISITS-1 JAN 18-JAN 18,1990		$ 48.01	$ 42.90
Amount approved limited by Item 5C on back.			
LE SOLBERG MD INPATIENT VISITS-1 JAN 19-JAN 19,1990		$ 164.84	$ 61.20
Amount approved limited by Item 5C on back.			
LE SOLBERG MD INPATIENT VISITS-1 JAN 19-JAN 19,1990		$ 48.01	$ 42.90
Amount approved limited by Item 5C on back.			
Total approved amount			$ 189.90
Medicare payment (80 % of the approved amount)			$ 151.92
Medicare adjusted payment (see remarks)	(30887)		$ 148.74

If you have other insurance, it may help with the part Medicare did not pay.

Paid 148.74
3-7-90

(You have met $ 75.00 of the $ 75.00 deductible for 1990)

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Sep 02, 1990 (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. *508-07-3997A* Claim Control No. *0290-046-541990*

02087

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

March 02, 1990

PERRY L POLLARD
230 EAST 30TH ST
SIOUX FALLS SD 57105-3923

For more information call or write
MEDICARE PART B
4510 13TH AVENUE S.W.
FARGO, NORTH DAKOTA 58121-0001
PHONE AREA CODE 701-282-0691
CALL TOLL FREE 1-800-437-4762

R E M A R K S :

We are paying a total of $ 148.74 to you on the enclosed check. Please cash it as soon as possible.

Under the current law, we have reduced your Medicare paymentby 2.092 percent for services you received between October 17, 1989 and September 30, 1990.

You are responsible for the total of $ 160.13, the difference between the Billed amount and the Medicare payment. Had your doctor accepted assignment, your bill would have been reduced $ 118.97, the difference between the Billed and Medicare Allowed amount.

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Sep 02, 1990 (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. 508-07-3997A Claim Control No. 0290-046-541990

02088

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

March 02, 1990

PERRY L POLLARD
230 EAST 30TH ST
SIOUX FALLS SD 57105-3923

For more information call or write
MEDICARE PART B
4510 13TH AVENUE S.W.
FARGO, NORTH DAKOTA 58121-0001
PHONE AREA CODE 701-282-0691
CALL TOLL FREE 1-800-437-4762

Participating doctors and suppliers always accept assignment of Medicare claims. See back of this notice for an explanation of assignment. Write or call us for the name of a participating doctor or supplier or for a free list of participating doctors and suppliers.

Your doctor or supplier did not accept assignment of your claim totaling $ 4566.23. (See Item 4 on back)

			BILLED	MEDICARE APPROVED
LE SOLBERG MD	CONSULTATION	JAN 14-JAN 14,1990	$ 139.08	$ 92.20
Amount approved limited by Item 5C on back.				
LE SOLBERG MD	INPATIENT VISITS-1	JAN 14-JAN 14,1990	$ 1200.29	$ 0.00
Medicare does not pay for this because it is included in the major surgical fee.				
LE SOLBERG MD	INPATIENT VISITS-1	JAN 14-JAN 14,1990	$ 2110.39	$ 1431.80
Amount approved limited by Item 5C on back.				
LE SOLBERG MD	INPATIENT VISITS-1	JAN 14-JAN 14,1990	$ 556.00	$ 153.80
Amount approved limited by Item 5C on back.				
LE SOLBERG MD	SURGERY	JAN 14-JAN 14,1990	$ 489.39	$ 196.15
The approved amount represents a reduction for the lesser surgery performed through the same incision or for a related surgical procedure.				
LE SOLBERG MD	INPATIENT VISITS-1	JAN 15-JAN 15,1990	$ 71.08	$ 41.60
Amount approved limited by Item 5C on back.				

Total approved amount	$ 1915.55
Medicare payment (80 % of the approved amount)	$ 1532.44
Medicare adjusted payment (see remarks)	$ 1500.38

If you have other insurance, it may help with the part Medicare did not pay.

(You have met $ 75.00 of the $ 75.00 deductible for 1990)

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Sep 02, 1990 (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us this:

Medicare Claim No. 508-07-3997A Claim Control No. 0290-046-542000

Paid 1500.38 3-7-90

02089

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

March 02, 1990

PERRY L POLLARD
230 EAST 30TH ST
SIOUX FALLS SD 57105-3923

For more information call or write
MEDICARE PART B
4510 13TH AVENUE S.W.
FARGO, NORTH DAKOTA 58121-0001
PHONE AREA CODE 701-282-0691
CALL TOLL FREE 1-800-437-4762

REMARKS:

We are paying a total of $ 1500.38 to you on the enclosed check. Please cash it as soon as possible.

Under the current law, we have reduced your Medicare paymentby 2.092 percent for services you received between October 17, 1989 and September 30, 1990.

You are responsible for a total of $ 3065.85, the difference between the Billed amount and the Medicare payment (this includes services that Medicare does not cover - shown as '$0.00' in the Medicare Allowed column). Had your doctor accepted assignment, your bill would have been reduced $ 1450.39, the difference between the Billed and Medicare Allowed amount.

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Sep 02, 1990 (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. 508-07-3997A Claim Control No. 0290-046-542000

02090

North Central Heart Institute

1100 S. EUCLID AVE., SUITE 500
1301 S. NINTH AVE., SUITE 305
2727 S. KIWANIS AVE.
SIOUX FALLS, SOUTH DAKOTA 57105
(605) 331-5394

APPOINTMENT WITH:
Raymond Allen, M.D.
Donald Bishop, M.D.
Paul Carpenter, M.D.
Jerry Moench, M.D.
Lewis Ofstein, M.D.
Leycester Owens, Jr., M.D.
James Reynolds, M.D.
Lloyd Solberg, M.D.
John Vander Woude, Jr., M.D.
Galen Vonk, M.D.

PERRY
230 E 30TH
SIOUX FALLS

L POLLARD

SD 57105

Unpaid balances over 120 days are subject to a monthly late payment charge

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT TO INSURE PROPER CREDIT

STATEMENT DATE	ACCOUNT BALANCE	ACCOUNT NO	AMOUNT ENCLOSED
01/31/90	4875.10	310208	$

PAYMENT RECEIVED AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

DATE OF SERVICE	PATIENT NAME	CPT CODE	CPT DESCRIPTION	DIAG.	DOCTOR	CHARGES	CREDITS
			* BALANCE FORWARD *			0.00	
01/14/90	PERRY	90630	COMPLEX CONSULTATION	414.0	SOLBERG	139.08	
01/14/90	PERRY	93549	COMBINED RHC,LHC,COR		SOLBERG	1200.29	
01/14/90	PERRY	92982	ANGIOPLASTY - ONE VE	414.0	SOLBERG	2110.39	
01/14/90	PERRY	92984	CORONARY ANGIOPLASTY		SOLBERG	556.00	
01/14/90	PERRY	33210	INSERT. OF TEMP. TRA		SOLBERG	499.39	
01/15/90	PERRY	99174	CRITICAL CARE VISIT	786.50	SOLBERG	71.08	
01/16/90	PERRY	90270	HOSPITAL VISIT-EXTEN	786.50	SOLBERG	48.01	
01/18/90	PERRY	90270	HOSPITAL VISIT-EXTEN		SOLBERG	48.01	
01/19/90	PERRY	93016	STRESS TEST-THALLIUM		SOLBERG	164.94	
			YOUR INSURANCE HAS BEEN FILED				
			FOR YOUR CONVENIENCE WE ACCEPT VISA OR MASTERCARD				
			12C DAY BALANCES CHGD 12.5% ANNUALLY FOR LATE PYMT				

NORTH CENTRAL HEART
1100 S. EUCLID AVE. SUITE 500
1301 S. NINTH AVE. SUITE 305
SIOUX FALLS, S.D. 57105
TAX ID. # 46-0360966

ACCOUNT NO.	STATEMENT DATE	OVER 90 DAY	OVER 60 DAY	OVER 30 DAY	CURRENT	AMOUNT DUE
310208	01/31/90	0.00	0.00	0.00	4875.10	4875.10

PAYMENT RECEIVED AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

DATE OF SERVICE	PATIENT NAME	CPT CODE	CPT DESCRIPTION	DIAG.	DOCTOR	CHARGES	CREDITS
			* BALANCE FORWARD *			0.00	
01/19/90	PERRY	90270	HOSPITAL VISIT-EXTEN		SOLBERG	48.01	
			YOUR INSURANCE HAS BEEN FILED				
			FOR YOUR CONVENIENCE WE ACCEPT VISA OR MASTERCARD				
			12C DAY BALANCES CHGD 12.5% ANNUALLY FOR LATE PYMT				

NORTH CENTRAL HEART
1100 S. EUCLID AVE. SUITE 500
1301 S. NINTH AVE. SUITE 305
SIOUX FALLS, S.D. 57105
TAX ID. # 46-0360966

ACCOUNT NO.	STATEMENT DATE	OVER 90 DAY	OVER 60 DAY	OVER 30 DAY	CURRENT	AMOUNT DUE
310208	01/31/90	0.00	0.00	0.00	4875.10	4875.10

North Central Heart Institute

1100 S. EUCLID AVE., SUITE 500
1301 S. NINTH AVE., SUITE 305
SIOUX FALLS, SOUTH DAKOTA 57105
(605) 331-5364

NCH
NORTH CENTRAL HEART INSTITUTE
CARDIAC, THORACIC & VASCULAR CARE

APPOINTMENT WITH:
Raymond Allen, M.D.
Donald Bishop, M.D.
Paul Carpenter, M.D.
Jerry Moench, M.D.
Lewis Ofstein, M.D.
Leycester Owens, Jr., M.D.
James Reynolds, M.D.
Lloyd Solberg, M.D.
John Vander Woude, Jr., M.D.
Galen Vonk, M.D.

A

PERRY L POLLARD
230 E 30TH
SIOUX FALLS SD 57105

Unpaid balances over 120 days are subject to a monthly late payment charge.

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT TO INSURE PROPER CREDIT

STATEMENT DATE	ACCOUNT BALANCE	ACCOUNT NO.	AMOUNT ENCLOSED
02/28/90	$5154.10	310208	$

PAYMENT RECEIVED AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

DATE OF SERVICE	PATIENT NAME	CPT CODE	CPT DESCRIPTION	DIAG.	DOCTOR	CHARGES	CREDITS
			* BALANCE FORWARD *			4875.10	
01/14/90	PERRY	99150	OPERATIVE STANDBY	414.0	L OWENS	279.00	
			YOUR INSURANCE HAS BEEN FILED				
			FOR YOUR CONVENIENCE WE ACCEPT VISA OR MASTERCARD				
			YOU ARE RESPONSIBLE FOR THE FULL BALANCE.				

NORTH CENTRAL HEART
1100 S. EUCLID AVE., SUITE 500
1301 S. NINTH AVE., SUITE 305
SIOUX FALLS, S.D. 57105
TAX ID # 46-0360980

310208	02/28/90	0.00	0.00	4875.10	279.00	5154.10
ACCOUNT NO.	STATEMENT DATE	OVER 90 DAY	OVER 60 DAY	OVER 30 DAY	CURRENT	AMOUNT DUE

PAYMENT RECEIVED AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

DATE OF SERVICE	PATIENT NAME	CPT CODE	CPT DESCRIPTION	DIAG.	DOCTOR	CHARGES	CREDITS
			* BALANCE FORWARD *			C.CO	
01/19/90	PERRY	90270	HOSPITAL VISIT-EXTEN		SOLBERG	48.01	
			YOUR INSURANCE HAS BEEN FILED				
			FOR YOUR CONVENIENCE WE ACCEPT VISA OR MASTERCARD				
			12C DAY BALANCES CHGD 12.5% ANNUALLY FOR LATE PYRT				

NORTH CENTRAL HEART
1100 S. EUCLID AVE., SUITE 500
1301 S. NINTH AVE., SUITE 305
SIOUX FALLS, S.D. 57105
TAX ID # 46-0360980

310208	01/31/90	0.00	0.00	0.00	4875.10	4875.10
ACCOUNT NO.	STATEMENT DATE	OVER 90 DAY	OVER 60 DAY	OVER 30 DAY	CURRENT	AMOUNT DUE